SOLICITATION, OFFER, AND AWARD

1. Caption	Page of Pages	
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2. Contract Number	3. Solicitation Number	4. Type of Solicitation	5. Date Issued	6. Type of Market
		[ ] Sealed Bid (IFB)		[X] Open
		[X] Sealed Proposals (RFP)		[ ] Set Aside
		[ ] Sole Source		[ ] Open with Sub-Contracting Set Aside
		[ ] Human Care Agreements		
	POTO-2006-R-0077	[ ] Emergency	6/30/2006	

7. Issued By:	8. Address Offer to:
Office of Contracting and Procurement 441 4th Street, NW, Suite 700 South Washington, DC 20001	Office of Contracting and Procurement 441 4th Street, NW Bid Room, Suite 703 South Washington, DC 20001

SOLICITATION

9. Sealed offers in original and 9 copies for furnishing the supplies or services in the Schedule will be received at the place specified in Item 8, or if hand carried to the bid counter located at 441 4th Street, NW, Suite 703 South until 2:00 P.M. (Hour) local time 11-Aug-06 (Date)

CAUTION: Late Submissions, Modifications and Withdrawals: See 27 DCMR chapters 15 & 16 as applicable. All offers are subject to all terms & conditions contained in this solicitation.

10. For Information Contact	A. Name	B. Telephone			C. E-mail Address
		202	727-8704	(Ext)	
	Veronica Singh				veronica.singh@dc.gov

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OFFER

12. In compliance with the above, the undersigned agrees, if this offer is accepted within 120 calendar days from the date for receipt of offers specified above, to furnish any or all items upon which prices are offered at the price set opposite each item, delivered at the designated point(s), within the time specified herein.

13. Discount for Prompt Payment	10 Calendar days %	20 Calendar days %	30 Calendar days %	____ Calendar days %

14. Acknowledgement of Amendments (The offeror acknowledges receipt of amendments to the SOLICITATION):	Amendment Number	Date	Amendment Number	Date

15A. Name and Address of Offeror		16. Name and Title of Person Authorized to Sign Offer/Contract		
15B. Telephone			15 C. Check if remittance address is different from above - Refer to Section G	17. Signature	18. Offer Date
(Area Code)	(Number)	(Ext)	[ ]		

AWARD (TO BE COMPLETED BY GOVERNMENT)

19. Accepted as to Items Numbered	20. Amount	21. Accounting and Appropriation

22. Name of Contracting Officer (Type or Print)	23. Signature of Contracting Officer (District of Columbia)	24. Award Date

Government of the District of Columbia — Office of Contracting & Procurement

SECTION B: SUPPLIES OR SERVICES AND PRICE

B.1 The Government of the District of Columbia , Office of Contracting and Procurement on behalf of the Department of Health, Medical Assistance Administration (the District), is seeking a Contractor to:

B.1.1 Provide, Enhance and Implement a federally owned and certified Medicaid Management Information System (MMIS) as set forth in Section C.3 through C.7.5.5. of this Request for Proposal (RFP). The Contractor shall enhance the MMIS by using current information technology to enable the efficient and responsive operation of the District' s Medicaid Program as described in Section C.1.

B.1.2 Provide services to operate the enhanced MMIS and process District Medicaid claims during the term of the contract, as set forth Sections C.8 through C.10.

B.2 The term of the contract shall be for a period of seven (7) years from date of award. The District contemplates award of a single contract containing the following three types of contract components:

1. Fixed-price component for system Enhancements and Implementation tasks as defined in Sections H.21 and H.22;

2. Requirements component with payment based on fixed unit prices for Operations as defined in Sections H.21 and H.23; and

3. A cost reimbursement component for postage as defined in Section G.9.4.

B.2.1 **REQUIREMENTS**

The District will purchase its requirements of the articles or services included herein from the Contractor. The estimated quantities stated herein reflect the best estimates available. The estimate shall not be construed as a representation that the estimated quantity will be required or ordered, or that conditions affecting requirements will be stable. They shall not be construed to limit the quantities which may be ordered from the Contractor by the District or to relieve the Contractor of its obligation to fill all such orders.

a) Delivery or performance shall be made only as authorized in accordance with the Ordering Clause, G.10. The District may issue orders requiring delivery to multiple destinations or performance at multiple locations. If the District urgently requires delivery before the earliest date that delivery may be specified under this RFP, and if the Contractor shall not accept an order providing for the accelerated delivery, the District may acquire the urgently required goods or services from another source.

b) There is no limit on the number of orders that may be issued. The District may issue orders requiring delivery to multiple destinations or performance at multiple locations.

c) Any order issued during the effective period of this RFP and not completed within that period shall be completed by the Contractor within the time specified in the order. The RFP shall govern the Contractor's and District's rights and obligations with respect to that order to the same extent as if the order were completed during the contract's effective period; provided, that the Contractor shall not be required to make any deliveries under this contract after the term of the contract specified in Section F.1.

B.3 The District will pay the Contractor through incremental payments following the District' s receipt and approval of the deliverables as determined by the Contracting Officer Technical Representative (COTR). Following the District' s receipt and approval of each deliverable, the Contractor shall prepare and submit an invoice to the COTR as set forth in Sections H.21 through H.23 of the RFP. The District will make payment based on the RFP price for that deliverable. The District will pay the Contractor for the ongoing operations tasks on the submission of a monthly claim processing report by the Contractor to the COTR.

B.4 PRICE SCHEDULE – Summary of Periods One through Seven

Enhancements and Implementation

(from Pricing Schedule B.4.1)

Period One $_____

Operations (from Pricing Schedules B.4.2)

Period Two $_____

Period Three $_____

Period Four $_____

Period Five $_____

Period Six $_____

Period Seven $_____

Total Price (For Periods One through Seven) $_____

B.4.1 Price Schedule for Enhancements and Implementation Tasks Period One (18 Months)

a) Amount for Successful Completion of the Phase 2 Design subtask (20% of the total amount for Enhancement and Implementation) as described in Section C.7.12 and Section H.22 $_____

b) Amount for Successful Completion of the Phase 2 Development/Testing (20% of the total amount for Enhancement and Implementation) as described in Section C.7.17 and Section H.22 $_____

c) Amount for Successful Completion of the Phase 3 Conversion Subtask (10% of the total amount for Enhancement and Implementation) as described in Section C.7.18 and Section H.22 $_____

d) Amount for Successful Completion of the Phase 3 Acceptance Testing Subtask (20% of the total amount for Enhancement and Implementation) as described in Section C.7.19 and Section H.22 $_____

e) Amount for Start of Operations (10% of the total amount for Enhancement and Implementation) as described in Section C.7.20 and Section H.22 $_____

f) Amount for Federal Certification (20% of the total amount for Enhancement and Implementation as described in Section C.5.7 and Section H.22 $_____

Total Firm Fixed Price Offer for Enhancement and Implementation (100%) **$_____**

B.4.2 Price Schedule for Operations

Period	Item Description	Estimated Number of Claims	Price Per Claim	Estimated Period Price
2 (12 Months)	Operations Sections C.8 & C.9	12,000,000	**$**_____	**$**_____
3 (12 Months)	Operations Sections C.8 & C.9	12,000,000	**$**_____	**$**_____
4 (12 Months)	Operations Sections C.8 & C.9	12,000,000	**$**_____	**$**_____
5 (12 Months)	Operations Sections C.8 & C.9	12,000,000	**$**_____	**$**_____
6 (12 Months)	Operations Sections C.8 & C.9	12,000,000	**$**_____	**$**_____
7 (06 Months)	Operations & Turnover Sections C.8, C.9, & C.10	6,000,000	**$**_____	**$**_____

B.4.3 OPTIONAL RESOURCE PERSONNEL

Periods 2 through 7 **As described in Sections C.4.3, and C.4.6**	**Health Care Data Analyst** **Monthly Rate** **(Notes 1,2)**	**Analyst/ Programmer** **Monthly Rate** **(Notes 1,2)**
Period Two	$_____	$_____
Period Three	$_____	$_____
Period Four	$_____	$_____
Period Five	$_____	$_____
Period Six	$_____	$_____
Period Seven	$_____	$_____

Note 1: Enter the monthly rate for one full time person working 160 hours per month.
Note 2: These rates are **not** to be transferred to Schedule B.4. These rates will be evaluated but will **not** to be considered in the total price offered. Please refer to subsection H.23 and L.8.4.

SECTION C: SPECIFICATIONS/WORK STATEMENT

C.1 SCOPE:

C.1.2 The District of Columbia requires the enhancement, implementation and operation of a certified Medicaid Management Information System (MMIS) to perform the functions described in this RFP and those that will be defined during requirements analysis phase as described in Section C.7.1 Design Subtask .

C.1.3 The solution the Contractor provides shall meet all requirements described in this solicitation, shall meet all HIPAA regulatory requirements, and must be certified by Center for Medicare and Medicaid Services (CMS). The solution shall have the following characteristics:

1) Contemporary functionality
2) Operational reliability
3) Enhancement capability
4) Maintainability
5) Portability
6) Capability to qualify for maximum Federal Financial Participation (FFP)

C.1.4 The District will determine that the proposed system has these characteristics.

C.1.5 The District is seeking a Contractor to provide an existing CMS-certified MMIS system with enhancements as specified by the District.

C.1.6 It is anticipated that the current Medicaid Management Information System will continue to be operated by the incumbent MMIS Contractor until the new system is in full operation as specified in Section H.37.7 of this solicitation.

C.1.7 Section C.1.8 details the automation and operational needs of the District Medicaid Assistance Administration being sought as part of this procurement. This section highlights those requirements the enhanced system must satisfy to support District Medicaid managers and Medicaid Management Information System (MMIS) users.

C.1.8 The identified functional system requirements are general in nature and impact the majority of applications within the MMIS. They include the following:

1. **Flexibility** - The Contractor shall design the new MMIS using a rules-based and table driven structure. The MMIS shall be user friendly and

shall facilitate program changes; maintenance and implementation of edits and audits; the adding of new provider types and specialty codes. These tables shall support add/change/delete transaction capabilities with all transactions appearing in an online, real time audit trail report.

2. **System Navigation** –The Contractor shall incorporate user friendly system navigation capabilities and a graphical user interface (GUI) that allows users to move freely throughout the system by accessing pull down menus and "point and click" navigation in the enhanced MMIS. In addition, the Contractor shall complete the navigation process without having to enter identifying data multiple times. "Help" screens shall be included and shall be context-sensitive in order to provide for ease of use.

3. **On-line Flexible Query Capability -** The Contractor shall include the capability to query data on-line for provider, recipient, reference, claims using multiple parameters, including partial match or wild card search/capabilities in the MMIS. For example, the ability to query claims information by provider identification, recipient identification, date of service, date of payment, procedure code, provider type, or any other element in the claim record, either in combination or separately.

4. **On-line Flexible Update Capability** - The Contractor shall provide flexible on-line update capability for provider, recipient, reference, claims, and other files, and manuals in the MMIS.

5. **On-line Viewing of Reports and Manuals** – The Contractor shall provide an MMIS that allows the users to view reports and manuals on-line.

6. **Claims and Data Storage -** The Contractor shall maintain six (6) years of adjudicated (paid and denied) claims history by paid date on a current, active claims history file for use in audit processing, on-line inquiry and update, and printed claims inquiries. All data in the claim record, claim attachments(s), files, tables, as well as the data supporting editing, auditing, and processing in force at the time of a claim's adjudication, must be maintained for six (6) years to support the claim processing, on-line display, retrieval, and reporting of these claims.

7. **Notes Functionality** - The District shall have the capability to accept, track, link, and secure MMIS user notations or comments. These notes relate to providers, clients, reference file updates, prior authorizations, surveillance and utilization review (SUR), and third party liability (TPL) actions.

8. **SURS/TPL Functionality** – The District seeks to obtain mission critical enhancements by including improvements in the new system such as a modern, user friendly Surveillance & Utilization Review subsystem and a case management system for use by both the Third Party Liability and SURS units to minimize the effect on providers and posture the District for efficient and effective future operation of the system to meet MAA mission and known District and Federal requirements.

9. **Other MMIS Enhancements** – The Contractor-led functional requirements work sessions shall result in the identification of additional functional requirements that shall be enumerated in the RFP.

C.1.9 This section describes the specifications and work tasks for providing, enhancing, implementing, operating and turning over the District of Columbia Medicaid Management Information System (MMIS). The requirements are divided into the following four areas:

1. Data Processing Requirements (C.3)
2. Organization and Staffing Requirements (C.4)
3. Operations Requirements (C.5)
4. MMIS Functional Requirements (C.6)

C.1.10 The Contractor shall include meeting each of the requirements presented in this section and the way that the requirement will be met shall be addressed in the Contractor's proposal.

C.1.11 APPLICABLE DOCUMENTS

Item No.	Title	Document Type	Date
1	State Medicaid Manual	42 CFR 433, Subpart C and Part 11	Current Version
2	Health Insurance Reform	42 CFR 433.112, 45 CFR Parts 160, 162 and 164	Current Version
3	CLIA regulations and related Federal Register publications	Clinical Laboratory Improvement Act (CLIA)	Current Version
4	Federal DUR regulations	OBRA 90	Current Version

C.1.11.1 The Contractor shall comply with the following MMIS applicable requirements guidelines:

1. Meet or exceed all system requirements in 42 CFR 433, Subpart C and Part 11 of the State Medicaid Manual;
2. Meet or exceed all requirements in accordance with 42 CFR 433.112, 45 CFR Parts 160, 162 and 164, [CMS-0149-F] Health Insurance Reform – relating to Standards for Electronic Transactions, Code Sets, Identifiers, Security, and Privacy of health information of Health Insurance Portability and Accountability Act (HIPAA) and National Provider Identifier (NPI).;
3. Meet or exceed all functional requirements identified in the RFP;
4. Provide the information and processing necessary to support the Clinical Laboratory Improvement Act (CLIA);
5. Begin processing of all claim types on or before the Operational Start Date as defined in **Paragraph H.37.6 OPERATIONAL START DATE – PERFORMANCE REQUIRMENTS.**

C.1.11.2 The five requirements listed in C.1.11.1, are followed by scope of work descriptions for the four major contractor tasks. The Contractor shall, under direction of the District, design, enhance, test, implement, operate, and maintain and modify a MMIS for the District of Columbia. The scope of work for this contract includes the following four major tasks:

1. Enhancement and Implementation Task (C.7)
2. Operations Task (C.8)
3. Modifications Task (C.9)
4. Turnover Task (C.10).

C.1.11.3 In each of the above subsections task is discussed in detail. The requirements, responsibilities, deliverables, and milestones for each task are divided into subtasks. The subtasks presented are to be considered by the offerors as the minimum requirements of this RFP. Although the subtasks are described sequentially, it is recognized that most methodologies will involve subtask overlap and complex

dependencies. The offeror's detailed project plan shall display each of these overlaps and dependencies. The completion of a task shall consist of District approval of all deliverables for that task. The payment approach for the Enhancement and Implementation Task and the Operations Task are presented in Subsection G of the RFP.

C.1.12 DEFINITIONS

Acceptance Testing - The last phase of MMIS testing prior to final acceptance of the system.

Ad Hoc - On-request or specially requested; not scheduled. Refers to one-time, special reporting requests.

Adjudicate - Determination of whether a claim, or claim adjustment, or void claim is to be paid or disallowed by the MMIS.

Adjudicated Claim - A claim which has moved from pending status to final disposition, either paid or denied.

Adjustment - A transaction which changes the payment amount, units of services, and/or other information on a previously paid claim.

AFDC - Aid to Families with Dependent Children.

Agency - Any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or other establishment of the executive branch of this state authorized to participate in any contract resulting from this solicitation.

Aid Category - The designation in which a person is eligible for medical and health care under Medicaid.

Allowable Service - A benefit authorized by the Medical Assistance Administration and rendered to an eligible recipient by an eligible provider.

ANSI - American National Standards Institute.

ANSI COBOL - The American National Standards Institute has published a 1968 and a 1974 set of standards for the industry's most widely used computer programming language COBOL (Common Business Oriented Language). ANSI COBOL compiler would meet one of these standards.

APC - Ambulatory Payment Classifications.

APD - Advance Planning Document. This document is prepared by a state Medicaid agency in advance of a Medicaid fiscal intermediary procurement and submitted to the Centers for Medicare and Medicaid Services for review. It documents the planned approach to the procurement and any modifications to the MMIS.

Appeals - The administrative process through which the recipients or providers can appeal adverse decisions in respect to eligibility, coverage or payment.

BENDEX - Beneficiary Data Exchange. A file containing data from the Federal government regarding all persons receiving benefits from the Social Security Administration and the Veterans Administration.

Beneficiary - The Medicare term for a recipient.

Benefits - A schedule of coverage that an eligible participant in the program receives for specific health care services for the treatment of illness, injury or other condition.

Billing Provider - The provider who is submitting the claim. Can be a different provider from the servicing or rendering provider.

Business Day - A normal work day beginning Monday through Friday at 8:00 a.m. and ending at 4:30 p.m. Eastern Standard Time, except District and Federal holidays.

Buy-In - The process by which a state elects to pay the monthly premium for Part A & B of Medicare.

Calendar Day - All days of the week including District and Federal holidays.

Capitation - A per-recipient prospective payment made to an at-risk provider. Usually covers all services rendered on behalf of the capitated recipient although partial capitation may exclude specialty services.

Case Manager - A person designated as the coordinator of resources for assigned recipients in order to efficiently and effectively coordinate care.

Categorically Needy - All individuals receiving financial assistance under the State's approved plan.

Category of Service - A classification of medical services authorized under Medicaid (e.g., physician, inpatient hospital, ICF, etc.).

CCM - Client Case Management.

CCMS - Client Case Management System.

Certification - A review by CMS of an operational MMIS in response to a state's request for seventy-five percent (75%) FFP to ensure that all legal and operational requirements are met by the system.

CFR - Code of Federal Regulations. The Federal rules that direct a state in its administration of a Medicaid Program and implementation and operation of an MMIS.

Check Register - An output of the Claims Processing Subsystem which list checks approved from the current adjudication cycle.

CICS - Customer Information Control System

Claim - A bill rendered by a single provider to the Medical Assistance Program for a specific service(s) rendered to a single recipient for a given diagnosis or set of related diagnoses. A claim can be submitted for payment in hard copy form, Electronic Media Claims (EMC), or directly through on-line transmission.

Claim Detail - MMIS produced reports displaying details of adjudicated claim history for selected providers and/or recipients, or based on other selection criteria.

Claim Line - A line item of a document or electronic media claim which bills for a specific service(s) for a single recipient from a single provider.

Clean Claim - An error-free claim or an adjustment which was originally received by the Contractor can be processed without obtaining additional information or substantiation from the provider of service or the Department.

CLIA - Clinical Laboratory Improvements Act.

CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

COBRA - Consolidated Omnibus Budget Reconciliation Act.

Confidentiality - All reports, files, information, data, tapes and other documents provided to and prepared, developed, or assembled by the Contractor shall be kept

confidential in accordance with federal and state laws, rules and regulations and shall not be made available to any individual or organization by the Contractor without prior written approval of the District.

Consequential Damage –
A "consequential damage" is a financial loss or injury to the District caused by the Contractor's failure to meet specified performance requirements. The "actual damage" to be paid as a result of such consequence is equal to the exact amount of financial loss incurred by the District as specified in the following paragraphs.

Contract - The written, signed agreement resulting from this RFP for operation of the MMIS.

Contractor - The successful offeror, after being awarded the single contract under the RFP.

Cost Avoidance - A term describing procedures or systems of ensuring that the recipient's known other non-Medicaid health insurance resources were pursued prior to payment by Medicaid. MMIS typically has edits that deny or pend a claim unless there is evidence that the claim had already been submitted to these entities.

Cost Factor - A percentage factor which indicates the percent of total charge paid to an institutional provider by Medicaid.

Cost Settlement - An auditing process by which interim claims payments to cost based providers are adjusted yearly to reflect actual costs incurred.

Covered Services - Service and supplies for which Medicaid will reimburse the provider.

CPAS - Claims Processing Assessment System required by CMS used to identify claims processing errors.

CPI - Consumer Price Index. Revised Consumer Price Index for Urban Wage Earners and Clerical Workers, U.S. City Average (1967 = 100), all items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

CPT-IV - Current Procedural Terminology - Fourth Edition. A unique coding structure scheme for all medical procedures approved by the American Medical Association.

Credit - A health care claim transaction which has the effect of reversing a previously processed claim that has a corresponding original claim transaction.

Crossover Claim - A claim for services rendered to a recipient eligible for benefits under both Medicare and Medicaid. These claims are initially adjudicated by the Medicare intermediary or carrier.

CRT - Cathode Ray Tube.

Cutover - The date on which the successful bidder begins full and complete operation of the LMMIS.

Data Element - A specific unit of information having a unique meaning.

DC WAN - District of Columbia Wide Area Network.

Denied Claim - A Claim for which no payment is made to the provider.

Diagnosis Code - The coding structure for all diagnosed medical conditions covered by Medicaid for claims payment.

Discussions - For the purposes of the RFP presentations, a formal, structured means of conducting written or oral communications/presentations with responsible Proposers who submit proposals in response to this RFP.

DME - Durable Medical Equipment. A category of service involving medical equipment and supplies for home or institutional use.

DRG - Diagnosis Related Group. A prospective inpatient hospital reimbursement methodology used in Medicare. Under DRG, a single flat amount is paid per discharge.

Disallow - To determine that a billed service(s) is not covered by Medicaid and will not be paid.

Disaster Recovery Plan - Plan developed and maintained by the Contractor for an orderly shutdown of operations along with detailed plans for resumption of operation.

Dispensing Fee - The dollar amount paid to a dispenser of drugs as compensation for his professional services.

Drug Rebate Program - A program mandated by OBRA >90 in which states are eligible to collect rebates from drug manufacturers for drugs paid under Medicaid in exchange for an open formulary.

DOH - Department of Health

Duplicate Claim - A Claim that is either totally or partially an exact or near duplicate of services previously paid. It is detected by comparison of a new claim to processed claims from history files.

DUR - A therapeutic drug utilization review program designed to identify recipients at high risk for drug induced illness, communicate these risk factors to physicians and pharmacies, and modify drug therapies to reduce or eliminate these risks.

DUR Committee - Administrative control mechanism that is a crucial element in the management of the pharmaceutical component of the Medicaid Program. The committee is composed of physicians and pharmacists.

EDP - Electronic data processing

EVS - Eligibility Verification System.

Effective Date of Contract - The effective date of the Contract shall be the day all signatures have been obtained.

Eligible Provider - A provider of health care services entitled to payment under the DC Medical Assistance Administration (MAA) for rendered authorized services to an eligible recipient as established and certified by the Department

Eligible Recipient - An individual entitled to health care services under the Medicaid Program as established and certified by the Department to the Contractor.

EMC - Electronic media claims (tape, disk, and telecommunications).

Encounter - In some states with capitated programs, the term for a pseudo-claim which must be submitted by the PHP/HMO for utilization reporting, not claims payment purposes.

Enhancement - An augmentation and/or a change to the MMIS. An improvement to the basic system which either increases functionality or makes the system run more efficiently.

EPSDT - Early and Periodic Screening, Diagnosis, and Treatment (for children under 21 years of age)

FFP - Federal Financial Participation. A percentage of State expenditures to be reimbursed by the Federal government for medical assistance and for the administrative costs of the Medicaid program.

Fiscal Intermediary - An organization under contract to perform functions such as claim processing for the Medicaid Program

GSD - General System Design. The definitive guidelines stating all systems requirements for a certifiable MMIS.

GUI - Graphical User Interface

HCBS - Home and Community Based Services

HCFA - Health Care Financing Administration (now referred to as CMS) of the U.S. Department of Health and Human Services

HIC - Health Insurance Claim number of the Medicare beneficiary

HCPCS - The CMS Common Procedure Coding System

HIPAA - Health Insurance Portability and Accountability Act

History File - A file containing extracts of all past paid claims (or past recipient activity or past provider activity) that can be used for surveillance and trend development.

HMO - Health Maintenance Organization.

Home Health Care - Any of the services, therapy, or equipment charges covered by Medicaid when the provider performs these services at the residence of the recipient.

Hospital Based Physician - A physician having an agreement with a hospital whereby he receives fees for services performed for that hospital.

ICD-9-CM - International Clarification of Diseases, Clinical Modification

Inpatient Care - All services and procedures covered by Medicaid when the recipient requires an acute hospital stay.

IMA - Income Maintenance Administration.

Institution - An organization which provides medical services for persons confined within its structure (e.g., hospital, nursing home, etc.).

Intermediate Care Facility (ICF) - A long-stay institution which provides care for a recipient, who is usually not bed-ridden, at a lower cost than inpatient hospital care.

LAN - Local Area Network.

LTC - Long-Term Care.

MAA - Medical Assistance Administration.

MAC - Maximum Allowable Cost. The highest unit cost at which a drug will be paid

Managed Care - A term denoting management of recipient care by a provider or case manager to encourage maximum therapeutic efficacy and efficiency through service planning and coordination. Also used in reference to prepaid, capitated health systems.

Manual Pricing - Pricing a claim "by hand". Usually performed due to the special nature of the service, e.g., no code exists; no allowed amount exists for a covered benefit, etc.

MARS - Management and Administrative Reporting Subsystem

Medicaid - The Title XIX Medical Assistance Program intended to provide Federal and State financial assistance for health and medical care of eligible persons.

Medicaid Quality Control (MQC) - Federally required review by the Department to verify the accuracy of claims paid.

Medical Review - Pre-payment review conducted by the Contractor to assure accurate payment for procedures and/or diagnosis that require review by medical professionals.

Medically Needy - Those individuals whose income and resources equal or exceed those levels of assistance established under a State or Federal Plan but are insufficient to meet their costs of health and medical services

Medicare - The Title XVII Hospital and Medical Insurance Program intended for persons 65 or older, blind, or disabled. The program is 100 percent financed by the Federal Government through SSA from the National Trust Fund.

Microfiche - An image storage media commonly used for storing claims history. The document is filmed, indexed and developed on individual microfiche.

Microfilm - An image storage media commonly used for storing claims history. The document is filmed, indexed and developed on individual microfilm rolls.

MMIS - Medicaid Management Information System

National Payer Identification - The National Payer Identification is a project in which a unique identifier, called a Payer ID, will be assigned to every payer of health care claims, eliminating the need for multiple numbering schemes.

NDC - National Drug Code. The national standard formulary 11 digit code used by most states to uniquely identify drugs. Codes are assigned by the FDA.

National Provider Identifier - A universally recognized, unique identifier assigned permanently to every provider of health care services or supplies by CMS.

OCTO - Office of the Chief Technology Officer.

OSCAR - Online Survey Certification and Reporting.

Parallel Testing - Testing based upon comparison of old and new system results. Requires a period of parallel operation where both systems operate and used the same data.

Pay and Chase - A term which denoting the practice of paying a claim in behalf of a recipient with third party resources and then recovering from the responsible parties. This is done when the third party resources are not known at the time of payment. Pay and Chase is most common with recovery claims involving casualty cases.

PDL - Preferred Drug List

Peer Review - An activity performed by group or groups of practitioners or other providers by which the practices of their peers are reviewed for conformance to generally accepted standards.

Pended Claim - A claim that is put in suspense by the Claims Processing Subsystem for some reason(s) requiring manual review and resolution by clerical or professional staff before further processing can take place.

PMP - Project Management Professional.

POS - Point of Sale.

Prepayment Review - Administrative sanction requiring review of a provider's claims prior to payment imposed against a medical service provider whose billing practice has been found in non-compliance with the Department's policies and procedures, and/or statues and regulations. This review shall be conducted by the Contractor.

Prior Authorization (PA) - Approval given in advanced by the Medical

Assistance program to a provider for a service to a recipient.

Procedure Code - The coding structure for all medical procedures covered by Medicaid. (See HCPCS).

Prospective-DUR - Prospective drug utilization review. A review of a patient's drug regimen before a prescription is filled.

Profile - An outline of the most outstanding characteristics of a provider practice in rendering health care services or of recipient usage in receiving health care services.

Provider - A person, organization, or institution certified to provide health or medical care services.

Recipient - A person eligible to receive the benefits of Medicaid/non Medicaid under one of several aid categories.

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Relational Data Base Management System (RDBMS) - A rules-based and table driven architecture with the interfacing subsystems, including claims processing, so they will function as one system on multiple physical platforms.

Remittance Advice (RA) - A document which accompanies a reimbursement check to a provider. It indicates the reason for pending, denial, and/or payment reductions from billed charges.

EOMB - Recipient Explanation of Medicaid Benefits. A notice issued to Medicaid recipients that explains the payment of services made on their behalf and requests verification that the service was actually received.

Retroactive - Refers to "back dated" coverage or service date in which a person was determined to be eligible for a period prior to the month in which the application was initiated.

Retrospective Drug Utilization Review - A review of a patient's drug regimen designed to identify patients at risk for drug induced illness and/or interactions.

Screening Services - Physical examinations and immunizations for recipients under age 21, with referral for special treatment if needed.

Service Limitation - A maximum amount of services allowable for a recipient for a given time period, such as 12 physician visits per fiscal year.

Skilled Nursing Home Facility - A long-stay institution which provides care for a recipient who is usually bed-ridden.

SMI - An SSA abbreviation for Supplemental Medical Insurance. It is also known as "Part B" of Medicare.

Specialty - The specialized area of practice for a physician, such as Pediatrics, Pathology, etc

Specialty Certification - Certification or approval by a National Professional Academy, Association, or Society which designates that this provider has demonstrated a given level of training or competence and is a "fellow" or specialist.

SSA - Social Security Administration

SSI - The Supplemental Security Income program administered by the Social Security Administration. This program replaced previous State administered programs for aged, blind and disabled recipients (except in Guam, Puerto Rico, and the Virgin Islands).

SSN - Social Security Number.

State Plan - The document by which the State outlines to CMS the amount, duration, and scope of Medicaid services to be provided and the reimbursement mechanism utilized in servicing specified groups of eligible.

SURS - Surveillance and Utilization Review Subsystem.

SURS Unit - The section of the Contractor's organization responsible for surveillance and utilization review activities in the District.

Surveillance - Activities designed to monitor the expenditure of Medicaid funds and services.

System - A set of computer and human oriented procedures which operate as a regularly interacting or interdependent group of activities forming a unified whole.

System Testing - The process integrates testing of all components of the system.

TCN - **Transaction** Control Number. A unique ten digit number including year, Julian date of receipt, media code, sequence, and line item assigned by the Contractor to all financial transactions except original claims for control purposes.

TCP/IP - Transmission Control Protocol/Internet Protocol

TEFRA - Tax Equity and Fiscal Responsibility Act.

Third-Party Liability (TPL) - A condition whereby a person or an organization other than the recipient or the Medicaid Program is responsible for medical costs incurred by the recipient (Workman's Compensation, health or casualty insurance company, another person in the case of an accident, etc.).

Transition - The system conversion from the Contractor to the State or successor Contractor.

Turnover - The transfer of the MMIS to the State and/or a successor Contractor

UB-92 - The latest version of the uniform hospital billing form approved by the American Hospital Association. This claim form is usually used by inpatient and outpatient hospitals.

UPIN - Unique provider identification number assigned by Medicare.

Usual and Customary Fee Schedule - The file containing the reasonable charges of a given procedure to be reimbursed to a practitioner. The reasonable charge can vary according to different regions in the District.

Utilization Review - The process of monitoring and controlling the quantity and quality of health care services delivered under Medicaid Program.

Waiver - An exception requested of or granted by CMS in response to a request from a state, usually regarding some required aspect of Medicaid regulations in order to implement a new program or system.

Workman's Compensation - A type of third-party coverage for medical services rendered as the result of an on-the-job accident or injury to a recipient for which his employer's insurance company may be obligated under the Workmen's Compensation Act.

Workstation equipment - for purposes of this RFP includes, but is not limited to: laser printers, microcomputers, terminal cabinetry, and site-specific communications devices that shall be installed in the District offices for the purpose of providing access to the MMIS database. It shall also include any

upgrades to existing LAN equipment and software, including bridges, servers, cables, and printers.

C.2 BACKGROUND

The District of Columbia's Medicaid program serves over 140,000 clients and utilizes over 7,000 service providers. Many of the current client population (over 90,000 individuals) receive their services through a managed care delivery mechanism. The District's current MMIS was designed and implemented to support the traditional fee-for-service delivery model and is not adequately suited to support the managed care environment especially in an era of rapidly changing and expanding programs.

C.2.1 The District of Columbia uses the services of a Contractor to operate and maintain the District's certified MMIS. The re-procurement of the services of a claims processing Contractor will support the District's $1.3 billion Medicaid program.

C.2.2 The Contractor selected by the District through the procurement process shall be required to provide to the District a system used in a currently operational and CMS certified MMIS and implement certain system enhancements and improvements prior to assuming operational responsibilities.

C.3 DATA PROCESSING REQUIREMENTS

The following subsections present the data processing requirements that the Contractor shall meet during the design, enhancement, implementation, and operation of the District of Columbia Medicaid Management Information System (MMIS).

C.3.1 SECURITY, PRIVACY, CONFIDENTIALITY, AND AUDITING

The Contractor shall ensure the MMIS system provides for safeguarding of data and for physical security of the processing facility. It shall incorporate features for maintaining program integrity to assure that the fiscal capabilities of the system are not abused. Additionally, the Contractor shall provide a system for access control to the data and system software. Finally, the Contractor shall provide adequate backup and recovery features to ensure that the service delivery function can continue in cases of system unavailability and that the system can be reconstructed in the case of a disaster at a data processing facility.

The Contractor shall ensure that the MMIS implementation and operations are in accordance with Federal regulations and guidelines related to security, confidentiality, and auditing. Relevant publications to include:

1. Guidelines for Implementing the HIPAA privacy act in accordance with 45 CFR 164.501 and 45 CFR 164.502(g) and security act in accordance with HIPAA Security Final Rule [45 CFR §160, 162 and 164.
2. Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB 41).
3. Reserved for future use
4. Reserved for future use.
5. An independent opinion on MMIS Type II SAS 70 Audit in accordance with the Generally Accepted Auditing standards (GAAS) established by the American Institute of Certified Public Accountants. See Section H.47 - SAS 70 – Audit of MMIS Scope of work.
6. The Contractor shall perform an independent HIPAA Security assessment and penetration test ongoing yearly or when major changes applied to the MMIS processing environment to conform with the Health Insurance Portability and Accountability Act (HIPAA). The District must approve the independent contractor selected to perform the tests. See Section H.48 – HIPAA Security ongoing assessment and penetration test.

C.3.1.1 On-Line and Application Security

The Contractor shall design and implement various levels of security within the MMIS on-line applications, including, but not necessarily limited to, the following features:

1. The Contractor shall provide unique log-on for each user;
2. The Contractor shall provide required passwords that will expire on a staggered schedule and that can be changed at any time by appropriate District or Contractor management personnel;
3. The Contractor shall provide restriction of application and/or function within application to specific log-on;
4. The Contractor shall provide audit trails of all transactions by log-on, time entered, and source of entry (terminal), including all attempted transactions;
5. The Contractor shall provide access control to all data and to the applications software; the system shall employ password protection to restrict access to varying hierarchical levels of data and function; passwords must restrict access to data on a "role-based security" basis as well as restriction of functions, including inquiry only capabilities; global access to all functions will not be permitted;
6. The Contractor shall provide the same hierarchical password protection, as well as a system-inherent mechanism for recording any change to a software module or subsystem. The Contractor shall propose procedures for safeguarding the District from unauthorized modifications to MMIS; and
7. Finally, the Contractor shall provide technical security to ensure unauthorized access to the communication network is not obtained.

The Contractor shall further ensure that the system design facilitates auditing of computer files and paper records and that audit trails are provided throughout the system, including any conversion programs. Additional specific requirements related to security, confidentiality, and auditing are detailed in the following subsections.

C.3.1.2 Physical Security

Regardless of the equipment configuration selected by the District, it is important that the Contractor shall implement effective physical security measures which shall be maintained for any proposed MMIS equipment sites. At a minimum, the Contractor shall provide for the MMIS project a method of restricting perimeter access to processor areas and secured storage areas through a card key or other comparable system, as well as accountability control to record access attempts, including attempts of unauthorized access. Physical security shall include additional features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

C.3.1.3 Program Integrity

The Contractor shall protect the integrity and confidentiality of recipient and other data by safeguards that assure information is not released without proper consent. Further, all individuals having access to the confidential data shall comply with the District rules and policies related to confidentiality.

C.3.1.4 Backup and Recovery

It is critical that the Contractor place procedures and facilities to ensure that, in the event of major problems at any processor site(s), a mechanism exists to reconstruct the system and the affected data. The Contractor shall address regardless of the physical architecture of the MMIS system, adequate backup and recovery mechanisms.

At a minimum, there are three types of situations which could arise and which shall be addressed by the Contractor to ensure ongoing operations:

1. The first type is a major disaster where the central computer installation and resident software are destroyed or damaged.
2. The second type of problem is system or application dependent. It can be the result of network failure, software error, or operational errors. The result may be that one or several days processing is invalid and consequently, the data is corrupted or invalid.
3. The third type of situation stems from the possibility that the system will be unavailable from time-to-time. Contractors are required to thoroughly describe their approach to maximizing system availability at the local level.

C.3.1.5 Audit and Control Requirements

C.3.1.5.1 Audit and control considerations are especially important where a large number of staff with diverse skill levels and responsibilities interface directly with the system. Audit and control features apply to all areas of a system and shall, therefore, be considered an integral part of the overall architecture of the system. The audit and control requirements for the MMIS are described below in terms of data control, error correction, and audit trails

C.3.1.5.2 The MMIS shall contain a sufficient number of controls that meets or exceeds the HIPAA requirements for Security and Privacy to maintain the integrity of the data and information involved. The Contractor shall provide the following three types of controls to the MMIS:

1. **Preventive Controls:** Controls designed to prevent errors and unauthorized events from occurring,
2. **Detective Controls:** Controls designed to identify errors and unauthorized transactions which have occurred in the system, and
3. **Corrective Controls:** Controls to ensure that the problems identified by the detective control are corrected.

C.3.1.5.3 The Contractor shall provide these controls at all appropriate points of processing – e.g., application, database, front end, infrastructure, and network.

C.3.1.5.4 The Contractor shall incorporate audit trails in the system to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded. The Contractor shall provide the ability to trace data from the final place of recording through to the source document. These audit trails shall be supported by listings, transactions reports, update reports, transaction logs, and application and system error logs.

C.3.1.5.5 The Contractor shall ensure that the system facilitates auditing of individual claims. This shall be accomplished by providing audit trails throughout the system and conversion programs which identify and track changes to master file data and all edits and audits encountered, resolved, or overridden.

C.3.1.5.6 The District will only permit global overrides of edits and audits in writing. The Contractor shall document use of other overrides and obtain approval from the District for the edit disposition manuals. Only authorized operators may override edits and audits. The Contractor shall create and maintain an audit trail of all approved override transactions.

C.3.1.5.7 The Contractor shall provide updates or changes to prices, reference files, recipient eligibility, third-party liability, and provider file data that is highly controlled and maintain the appropriate audit trails. The Contractor shall report all updates to MMIS files and all error (rejected) update transactions to the District.

C.3.1.5.8 The Contractor shall update each record changed with the date of the change and the identification of the person making the change. These dates and identifications shall display on any on-line inquiry screens and reports showing file data.

C.3.1.6 Security Administration

Security features are only effective if utilized in conjunction with a prescribed security plan. The District will monitor the Contractor's security administration to ensure that the features built into the system are continuously effective. The Contractor shall perform security maintenance function to include periodic review of processor site(s) as well as periodic changes in passwords.

C.3.2 MMIS HARDWARE AND SOFTWARE

C.3.2.1 The District intends to maximize new technology and mainframe integration. The Contractor shall provide new technology to include:

1. Workstation equipment that adheres to the District's standards;
2. Video Conference through broadband connections to the Internet;
3. Document Imaging and Document Management
4. Microsoft Internet explorer compatible solution with standard web navigation functionality

C.3.2.2 The technology shall provide the new hardware and software to enhance the system's function in a cost effective manner and meets the District's technology standards. Any proposed interfaces with District equipment, and integration of District equipment resources into proposed solutions, shall conform to District hardware and software as stated in OCTO's Professional Guide To IT Architecture and Security Standards, DC Government 2005 which is posted at www.OCTO.dc.gov.

C.3.2.3 Workstation Equipment

C.3.2.3.1 The Contractor shall provide workstation equipment which includes, but is not limited to: laser printers, microcomputers, terminal cabinetry, and site-specific communications devices that shall be installed in the District offices for the purpose of providing access to the MMIS database. It shall also include any upgrades to existing LAN equipment and software, including bridges, servers, cables, and printers.

C.3.2.3.2 The Contractor following an approved project plan by the District shall install approved workstation equipment at the offices within the first month after the contract award. The Contractor shall develop a final list of workstation

locations which will be approved by the District as a subtask within the Enhancement and Implementation Task.

C.3.2.3.3 Equipment characteristics that shall meet the minimum requirement in configuring the optimum technology as defined by the District Technology Office standards and the minimum workstation for CICS like systems screens, if proposed shall include:

1. Keyboard features,
2. CRT screen display size and graphics capability,
3. Need for upper and lower case character display on CRT screens,
4. Extensive use of numeric characters,
5. Screen print capability,
6. Degree of intelligence at workstation,
7. Equipment footprint and overall size,
8. System security, and
9. Printer speeds.

C.3.2.4 Video Conferencing

The Contractor shall implement Video Conferencing via the Internet using the TCP/IP technology in the local DC area, and other remote facilities during development and/or continuous modification support with the local District and Contractor' s staff.

C.3.2.5 Imaging

The Contractor shall maintain imaging files, provide MAA access and retrieval functions to those files, and create any new imaging environment proposed to meet the functional requirements of this RFP. The Contractor shall convert historical images to the new environment and provide MAA access and retrieval capability. The specifications for the formats and protocols used to create and store the current imaging files are contained in the procurement library

C.3.3 SYSTEM RESPONSE TIME

The following subsection describes various response time standards.

C.3.3.1 System Response Time Standards

C.3.3.1.1 The District shall measure the response time during normal working hours, which are 7:00 a.m. to 5:30 p.m., Eastern Time, Monday through Friday, except for District holidays.

C.3.3.1.2 The District shall measure the response time of workstations connected to a processor and not functioning in stand-alone mode. The District shall measure the following elements of response time:

C.3.3.1.2.1 **Record Search Time** - The time elapsed after the search command is given (after entering the data keys for the search) until the list of matching records begins to appear on the terminal device.

C.3.3.1.2.2 **Record Retrieval Time** - The time elapsed after the retrieve command is given until the client data begins to appear on the terminal device.

C.3.3.1.2.3 **Screen Edit Time** - The time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with the errors highlighted.

C.3.3.1.2.4 **New Screen/Page Time** - The time elapsed from the time a new screen is requested until the data from that screen starts to appear on the terminal device.

C.3.3.1.2.5 **Prints Initiation Time** - The elapsed time from the command to print a screen or report until it appears in the appropriate queue.

C.3.3.2 System Response Time Requirements

C.3.3.2.1 The Contractor shall ensure that response times meet the following minimum standards. The District shall measure the above elements response time at intervals of 15 minutes during a randomly selected day each month. The Contractor shall provide a system that meets the following minimum standards:

C.3.3.2.1.1 **Record Search Time** - The response time must be within six (6) seconds for 98 percent of the record searches.

C.3.3.2.1.2 **Record Retrieval Time** - The response time must be within four (4) seconds for 98 percent of the records retrieved.

C.3.3.2.1.3 **Screen Edit Time** - The response time must be within three (3) seconds for 98 percent of the time.

C.3.3.2.1.4 **New Screen/Page Time** - The response time must be within one (1) second for 98 percent of the time.

C.3.3.2.1.5 **Prints/Initiation Time** - The response time must be within three (3) seconds for 98 percent of the time.

C.3.4 SYSTEM ACCESS AND NAVIGATION

C.3.4.1 The Contractor shall incorporate user friendly systems navigation technology and a graphical user interface that allows all MMIS users to move freely throughout the system using pull down menus, window tabs, and "point and click" navigation following industry best practices and standards for system usability. In addition, the navigation process shall be completed without having to enter identifying data more than once. The use of GUI access shall be standardized throughout the MMIS. The Contractor shall provide a system which shall contain a user-friendly menu system, understandable by non-technical users, that provides access to all functional areas.

C.3.4.2 This menu system shall be hierarchical and provide submenus for all functional areas of the MMIS. However, the menu system shall not restrict the ability of experienced users to directly access a screen, or the ability to access one screen from another without reverting to the menu structure.

C.3.4.3 Menus shall reflect the hierarchical or tree structure of the screens. Each menu item shall indicate a list of screens or a list of submenus to indicate screen dependencies to the users. The system shall remain available to the user from log on to system log off, without the need for intermediate system prompts. The display shall provide for both upper and lower case alphabetic characters. There may, however, be instances where the District will direct the Contractor to limit certain displays to only upper or lower case displays. The system access, display, and navigation requirements shall be standard for all users of the MMIS, including users from other agencies and entities.

C.3.4.4 The Contractor shall provide for a context-sensitive access to a help facility from any screen and any screen field. The MMIS shall contain drop down lists for the users to identify options available, valid values, and code descriptions, by screen field. The graphical user interface shall not, in any part, consist of what is commonly known as 'screen Scraped' presentations of the output of the transferred system.

C.3.5 CONSISTENCY OF DATA IN THE SYSTEM

The Contractor shall provide a MMIS system which shall provide consistent information to the District. Therefore, the District mandates the following standards be used for all screens and reports:

1. All headings and footers must be consistent with the standards agreed upon by the District.
2. PF-key usage must be consistent and displayed on all screens throughout the system on GUI or CICS screens with a GUI front end with pull-down menus, point and click navigation and context-sensitive help. Only those PF-Keys, which are available for the screen, are to be displayed (screens only). This requirement is relevant only for MMIS systems using CICS.
3. Current date and time must be displayed.
4. All references to dates must be displayed consistently throughout the system. Century must be displayed and the date format must be mm/dd/yyyy. See Subsection C.3.6 for further century date requirements.
5. All data labels used must be consistent throughout the system and clearly defined in user manuals and data element dictionaries.
6. All MMIS generated error messages must be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English Text. For example, Explanation of Benefits, HCPCS definitions, and diagnosis definitions should be written completely and in English.

C.3.6 CENTURY DATES

The Contractor shall design the MMIS so that all dates stored must identify the century and use it correctly in calculations.

C.3.7 SYSTEM INTERFACES

The Contractor shall design an MMIS that will accept and send data on-line and using electronic media from other District agencies and federal governments as external sources in the format required by the District or federal agencies. All MMIS files, programs, and data shall be available in real time to the District or Federal government upon request. This requirement includes capability to provide automated data interface for a regular data exchange with external systems without any human intervention.

C.3.8 SYSTEM TABLES/FILES

C.3.8.1 The Contractor shall make available all MMIS tables/files, programs, and data to the District or federal government in real time and upon request. The Contractor shall provide equipment and on- line inquiry access to all tables/files, database(s), programs, and data at the Contractor's local facility to authorized District personnel. In addition to any tables/files and/or extracts of tables/files that are scheduled to be delivered to the District, the Contractor shall provide a copy of any other table/file,

along with documentation of its format, within five (5) working days of a written request from the district. Each table/file request shall identify the files and the version, the "as of" date, sequence, media, and number of copies. The Contractor shall receive no additional compensation for production and delivery of such tables/files.

C.3.8.2 The Contractor shall maintain all MMIS tables/files for a minimum 90-day period following the update of the table/file with a more recent version, unless a longer period is indicated elsewhere in this document or is mandated by Federal requirement in which case the requirement for the longer period of maintaining the table/file shall prevail.

C.3.9 SOFTWARE AND HARDWARE COMPATIBILITY

C.3.9.1 The Contractor shall provide programming languages approved by the District for all GUI front-end, database, middleware, and communications software that shall be compatible with the District-computing environment. Alternate languages may be proposed with the understanding that they must be approved by the District. At the time of any Turnover, the Contractor must take any actions necessary, including software and data conversion, to enable the MMIS to be fully operational in the District computer environment.

C.3.9.2 The Contractor's telecommunications network shall be compatible with the District's standards for platforms and interconnections unless there are mutually agreed upon exceptions.

C.3.9.3 A listing of District approved languages and standards are available in the procurement library located at 2100 Martin Luther King Avenue, SE, Washington, DC 20020.

C.3.10 CLINICAL CASE MANAGEMENT

The Clinical Case Management System (CCMS) is designed to provide a system for the management of individual client's plans of care. This management system shall enable MAA nursing staff to plan, implement, document, evaluate, coordinate or manage individual health care delivery. The envisioned system shall be an independent component of the MMIS. The system shall be Windows based and shall be shareable by District staff over the DC WAN.

The Contractor shall propose a solution for this function expressed as follows:

C.3.10.1 Inputs

The Clinical Case Management function must accept the following inputs:

(a) Client data;
(b) Provider data;

(c) Client assessment file;
(d) Client health services file;
(e) Information from the Clinical Record;
(f) Updates from CCM workers; and
(g) Current ICD, DRG, CPT, and HCPCS code tables;

C.3.10.2 Processing

The Clinical Case Management function shall have the following processing capabilities:

C.3.10.3 The application shall be web-enabled to allow for access by field staff. Web page content must be in accordance with W3C HTML standards and allow delivery over proxy servers.

C.3.10.4 Point and click telephone dialing from the recipient or provider record.

C.3.10.5 The clinical case management function shall provide a complete patient information notebook, populated with data derived from the eligibility system interface. Data shall include patient and member demographics, benefit plan summary and history, Primary Care Practitioner/OBGYN designations, and unlimited custom data fields that users can add without intervention from developers.

C.3.10.6 The clinical case management function shall provide a complete provider information notebook, populated with data derived from the provider system. The data shall include provider demographics, specialty designation(s), network affiliation, and unlimited custom provider data fields that users can add without intervention from developers.

C.3.10.7 Maintain password control, in varying levels of security, of staff making changes to clinical case management data. System should be able to authenticate users through external authentication sources (example, Microsoft ADAM-based LDAP).

C.3.10.8 The system shall include outcome tracking (using industry standard or user defined tools).

C.3.10.9 The system shall include an integrated flag and scheduling function.

C.3.10.10 The system shall include integrated coding tables.

C.3.10.11 The clinical case management function shall provide automated medical review criteria.

C.3.10.12 The clinical case management function shall be capable of assigning a status of "suspended for medical review" to claims and maintaining claims on a suspense file.

C.3.10.13 The clinical case management function shall provide access to the claims history and shall contain diagnoses, procedures, all visits, prescriptions, institutional stays and episodes of care.

C.3.10.14 The clinical case management function shall provide the ability to flag and monitor recipients who shall be receiving restricted services.

C.3.10.15 The clinical case management function shall provide a workflow process that organizes and presents scheduled activities and tickler items for all users including an automated to-do listing of referrals.

C.3.10.16 The clinical case management function shall provide unlimited notes at both the patient and case level. Patient notes shall be able to span all cases for a given patient and permit all case and utilization managers to share patient information, such as clinical findings and history, psychosocial history, laboratory, pharmacy, and other information.

C.3.10.17 The clinical case management function shall provide security at a field, record and user level.

C.3.10.18 The clinical case management function shall provide patient and case- level alerts that quickly caution the care manager to a specific condition (for example, Disease Management Program, Quality Review, Litigation, Coordination of Benefits, Language Barrier, and so forth).

C.3.10.19 The clinical case management function shall support primary diagnosis and unlimited complications/co-morbidities coded in ICD-9 (or ICD 10 if implemented) or DRG codes (custom codes can be added and ICD-10 should be supported when promulgated).

C.3.10.20 The clinical case management function shall contain a complete graphical Treatment Plan, including all planned and reviewed procedures, services, admissions/LOS, medications, and so on. The treatment plan should be coded in HCPCS, CPT-4, or ICD-9 (or ICD 10 if implemented) service codes (custom codes can be added).

C.3.10.21 The clinical case management function shall provide alternative healthcare pathways to support efficient referral management.

C.3.10.22 The clinical case management function shall have the ability to record averted/avoided care and discounts for use in savings calculations.

C.3.10.23 The clinical case management function shall provide an automated schedule and should route activities for multiple users (nurses, physicians, others) electronically.

C.3.10.24 The clinical case management function shall provide the ability to access any commercially available or internally developed clinical criteria and guidelines. The user shall be permitted to enter and modify all business and clinical rules through an

intuitive user interface. This interface shall offer total control over all criteria/guidelines without requiring developer intervention. Users shall be able to quickly and efficiently access criteria that may differ by customer or business unit, patient factors such as age or sex, provider or provider network, treatment setting, diagnosis, and procedure/service. These criteria and guidelines shall be usable as baselines to track plans of care.

C.3.10.25 Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.3.10.26 The clinical case management function shall provide for automated identification and referral of case and disease management candidates.

C.3.10.27 The clinical case management function shall be Windows based with point and click navigation to any level of detail data and the ability to open and view multiple screens concurrently. The function shall provide documentation and on- line context sensitive help. Users should also be able to use the Help Facility to place their own Procedure and Policy documentation on- line.

C.3.10.28 The clinical case management function shall provide an automated interface to the claim system(s) to ensure the timely and complete transmittal of all data necessary to the claims payment process.

C.3.10.29 The clinical case management function shall provide the ability to add an unlimited number of custom fields, all of which are reportable.

C.3.10.30 The clinical case management function shall provide outcomes tools to support both case- level and aggregate reporting of financial and clinical/functional outcomes information.

C.3.10.31 The clinical case management function shall support ad-hoc reporting, data analysis and graphical data presentation. The system shall also produce a set of standard, parameter driven management reports.

C.3.10.32 The clinical case management function shall contain a message board accessible by all users of the system and other authorized individuals.

C.3.10.33 The clinical case management function shall provide the capability to query based on record number, recipient and provider ID, name and date of birth or social security number or by disease.

C.3.10.34 The CCMS shall provide on- line, updateable letter templates for provider or recipient letters with the ability to add free form text specific to a provider or recipient.

C.3.10.35 The clinical case management function shall have the ability to generate, modify and distribute treatment plan and other pertinent notes over the state LAN.

C.3.10.36 The clinical case management function shall have the capability to assign acuity criteria.

C.3.10.37 The clinical case management function shall make staff assignments and track the progress and timing of all staff assignments.

C.3.10.38 All clinical case management data should be exported to the data warehouse on a monthly basis.

C.3.10.39 Provide and maintain flexibility in coding structures by use of parameter and table oriented design techniques to enable rapid processing modifications in order to support Medicaid health care program and clinical case management changes.

C.3.10.40 The CCMS shall maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times.

C.3.10.41 The CCMS shall provide for context-sensitive help on screens for easy,

C.3.10.42 The CCMS shall maintain an on-line audit trail of all updates to clinical case management data.

C.3.10.43 The CCMS shall edit all data for presence, format, and consistency with other data in the update transaction and on all clinical case management processing and data related files.

C.3.10.44 Outputs

The Clinical Case Management function shall provide the following outputs and support the following information needs:

C.3.10.44.1 All data shall be available for retrieval through the DSS/DW function.

C.3.10.44.2 All reports shall be made available in data format for export and import purposes and through multiple media including paper, CD-ROM, electronic file, microform, diskette, and tape cartridge in PDF and/or Microsoft Office formats.

C.3.10.44.3 Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.3.10.44.4 Generate reports showing:

(a) Standard reports,
(b) Cost savings reports,
(c) Tracking reports of referrals and appeals,
(d) To do list reports,

(e) HEDIS like reporting,
(f) Letter generation with the ability to integrate text into correspondence,
(g) Ad hoc reports, and
(h) Graphical presentations.

C.3.10.44.5 Interfaces

The Clinical Case Management function has an external interface with commercially available clinical criteria. The system should be able to expose important internal functions as Web Services (example: create new client record from external MMIS payload) and consume external Web Services (example: address validation during client intake)

C.4 ORGANIZATION AND STAFFING REQUIREMENTS

This subsection describes the Contractor staffing requirements applicable to the Enhancement, Implementation, and the Operations/ Modifications tasks. Also described are the optional resource personnel requirements necessary to support the District's development and implementation of future Medicaid policy and program changes.

C.4.1 KEY PERSONNEL FOR IMPLEMENTATION

Key personnel required for the Enhancement and Implementation Tasks are:

1. Project Manager/Account Manager
2. Implementation Task Manager
3. Conversion Task Manager
4. Implementation/Claims Processing Manager

C.4.2 KEY PERSONNEL FOR OPERATIONS

Key personnel required for the Operations and Modifications Tasks are:

1. Project Manager/Account Manager
2. Operations/Claims Processing Manager
3. Modifications Task Manager
4. System Analysts
5. Provider Relations Manager

C.4.3 OPTIONAL RESOURCE PERSONNEL (TO BE HOUSED AT MAA)

The Contractor shall provide, within five (5) business days of the District's request, optional resource personnel for ongoing Medicaid policy and program support. The District may require one or more of these personnel at any time during the contract period. Optional Resource Personnel are:

1. Health Care Data Analysts
2. Analyst/Programmers

C.4.4 GENERAL REQUIREMENTS FOR KEY PERSONNEL

General requirements for key personnel are as follows.

1. The key personnel and their immediate staff shall provide the services in their District of Columbia location to meet the requirements of Section C and to perform the functions specified.
2. The Project Manager/Account Manager shall be employed by the offeror when the proposal is submitted.
3. All key personnel, in addition to the Project Manager, shall be employed by or committed to join the offeror's organization by the beginning of the Enhancement and Implementation Task.
    a) The District reserves the right to approve or disapprove all initial or replacement key personnel prior to their assignment to the MMIS project.
    b) The District shall have the right to require the Contractor to remove any individual (key personnel or otherwise) from assignment to this project for failure to perform their daily functions, with 15 days notice.
4. One member of the Key Personnel team for operations shall be consistently responsible for coordination and liaison with MAA.

C.4.5 MINIMUM QUALIFICATIONS FOR KEY PERSONNEL

Minimum qualifications for key personnel are as follows:

1. Project Manager/Account Manager:
    a) At least five (5) years as a Claims Processing System Manager for an MMIS or other large-scale medical claims processing system.
    b) Previous experience with an MMIS, or with major components of an operational MMIS.

c) Project Management Professional (PMP) certification.

2. Implementation Task Manager:

   a) At least three (3) years of experience in managing an MMIS design, Enhancement, and Implementation effort.

   b) Previous experience with the MMIS proposed by the offeror.

3. Conversion Task Manager:

   a) Experience with the conversion effort on an MMIS or other large-scale system implementation project.

4. Implementation/Operations Claims Processing Manager:

   a) At least three (3) years of experience in managing the claims processing component of an MMIS.

   b) Previous experience with the MMIS proposed by the offeror.

5. Modifications Task Manager:

   a) At least three (3) years experience in MMIS development or ongoing maintenance and modification.

   b) Experience with implementing major modifications to an MMIS or other large-scale claims processing system.

6. System Analysts:

   a) At least three (3) years experience in MMIS development or ongoing maintenance and modification.

   b) Three (3) years experience with MMIS.

7. Provider Relations Manager:

   c) At least three (3) years experience managing the provider relations function in Medicaid or other major public or private health care program.

   d) Three (3) years experience with MMIS.

C.4.6 MINIMUM QUALIFICATIONS FOR OPTIONAL RESOURCE PERSONNEL

Minimum qualifications for optional resource personnel are as follows:

1. Health Care Data Analysts:

   a) Degree from accredited four year college or university; advanced degrees preferred.
   b) At least three (5) years experience in Medicaid policy development and post-payment analysis.

2. Analyst/Programmer:

a) Degree from accredited four year college or university; advanced degrees preferred.
b) At least three (5) years experience in implementing Medicaid policy and program changes.
c) Project Management Professional (PMP) certification.

C.4.7 DISTRICT MMIS PROJECT MANAGER

The District will assign a full time District MMIS Systems Program Manager to work directly with the Contractor and manage the participation of three (3) FTE District employees during the Enhancement and Implementation Task. Program Management Office consultants will also provide deliverable review and monitoring support to assist the District's systems team.

C.5 OPERATIONS REQUIREMENTS

This subsection describes general requirements for Contractor support of ongoing Contractor and MMIS-related operational activities.

C.5.1 LOCATION OF CONTRACTOR OPERATIONS

The District will not provide any office space or facilities to the Contractor. The Contractor shall identify where (location) each MMIS-related and Contractor service function will be performed. The Contractor shall maintain a facility within the city limits of District of Columbia throughout the term of the contract.

The Contractor shall perform the following functions at their District facility:

1. Contract administration/District liaison (key personnel).
2. Claims receipt, prescreening, and putting claims and other documents to imaging in a digitizing format.
3. Data entry (hard-copy and EMC transactions).
4. Exception claims processing (suspense resolution).
5. Check request-related activities.
6. Business operations (warrant to CFO, accounts receivable handling, cash activity).
7. Production of newsletters, manuals, and so forth.
8. Provider relations and provider enrollment.
9. Report printing (except MARS and utilization management).

10. Space for up to two (2) District staff equipped with appropriate parking, furniture and work stations which allow access to the MMIS.

The Contractor may perform other MMIS functions, including computer processing, outside of the District, but within the continental United States. The District must approve the site of computer processing.

C.5.2 MMIS EQUIPMENT NEEDS

The Contractor shall provide all equipment identified in their offer. This equipment shall include, but is not limited to: computer workstations, modems, PCs, printers, telecommunications circuits, routers, switches, and related service required by the District and the Contractor for MMIS functions. The Contractors shall identify the optimal equipment requirement. If additional equipment is needed to meet the MMIS performance standards as defined in this RFP, the Contractor shall provide such equipment at no cost to the District.

C.5.3 DRUG POINT OF SALE CONTRACTOR INTERFACE

The Contractor shall provide Provider, Recipient Eligibility, and Reference file data to the point of sale Contractor to support POS claims processing. The Contractor shall accept adjudicated to be paid claims from the POS Contractor and process them for payment.

C.5.4 ON-LINE DATA UPDATES

The Contractor shall propose a system that has the capability for on-line real-time updates to all MMIS files. The security requirements identified in Subsection C.3 of this RFP shall be strictly adhered to for all updates to MMIS data. All on-line updates shall have built-in edits to ensure data integrity is maintained throughout the MMIS. Any screen with multiple edits must edit the entire screen and identify all fields in error. The MMIS on-line files shall be available for District use on all District workdays from 7:00 a.m. to 7:30 p.m., Eastern Time, Monday through Friday.

C.5.5 ON-LINE INQUIRIES

C.5.5.1 The Contractor shall propose a system that has on-line real time inquiry features to allow immediate access to all MMIS master files, databases, reports, data, etc. Inquiry screens shall not allow the update of data -except key search and function fields - on the inquiry screen. The use of identical screens to those that are for update is permitted providing all data fields are protected from update. The protection of data fields shall be a function of the screen; security level protection only at the data level on inquiry screens is not

permitted. The security requirements identified in Subsection C.3 of this RFP must be strictly adhered to for all inquiry only screens.

C.5.5.2 When users request printing of claims or other data from on-line inquiry screens, the system shall be capable of first identifying the number of records that will be produced if the request is activated. This feature shall prevent the unintentional printing of voluminous amounts of data.

C.5.6 SYSTEM AND USER DOCUMENTATION

C.5.6.1 The Contractor shall prepare user manuals for each system function as described in Section C.7.5. The Contractor shall prepare user manuals in draft form during the Development/Testing subtask and in final form during the Acceptance Testing subtask. During the Operations and Modification Tasks, the Contractor shall prepare updates to the user manuals in final form on all changes, corrections, or enhancements to the system within one week of District's technical sign off of the system change. The Contractor shall be responsible for the production and distribution of all user manual updates to the District.

C.5.6.2 The Contractor shall develop, updated, and distribute Provider manuals to the District after the District's review and acceptance. The Contractor shall create, review, and distribute the provider manuals as identified above. These manuals shall contain instructions on how to submit claims, adjudication process to assist in the determination of recipient benefits.

C.5.6.3 The Contractor is responsible for providing to the District complete, accurate, and timely documentation of the MMIS. The Contractor shall provide the MMIS Systems Documentation within thirty (30) days following District acceptance of the MMIS.

C.5.6.4 District acceptance will not be given and the final System Documentation cannot be delivered if portions of the MMIS are not functioning properly. During the Operations and Modifications Tasks, the Contractor shall provide updates to the MMIS System Documentation within one week of District's technical sign off of the system change.

` SYSTEM CERTIFICATION

The MMIS which is implemented as a result of this procurement shall meet all federal standards and possess all functional capabilities required by CMS for certification, as described in Part 11 of the State Medicaid Manual and in 42 CFR 433, Subpart C. Costs incurred to obtain federal certification are to be borne by the Contractor.

C.5.7.1 Federally Required Functions

The MMIS shall perform functions and possess capabilities specified in the Part 11 of the State Medicaid Manual and in 42 CFR 433, Subpart C published as of the contract start date. The Contractor shall meet all federal requirements for MMIS functionality, documentation, security, control, data elements, reporting, interfaces, data integrity, operations, processing, and any other requirement specified in available federal documents related to certification. The Contractor shall be responsible to provide the most current MMIS certification if the requirements are updated by CMS before implementation date.

C.5.7.2 Federally Required Data Elements

The MMIS shall include all data elements identified in Part 11 of the State Medicaid Manual, Section C.1.11 Applicable Documents.

C.5.7.3 MMIS Certification Schedule Deliverables

The contractor shall create and provide a schedule for the following requirements document with their proposal to be approved by the District to conduct the MMIS Certification activities which shall be completed before implementation**:**

C.5.7.3.1 Identify a list of certification requirement criteria based on the Contractor' s experience with certification or by subcontracting with an expert in the area of certification.

C.5.7.3.2 Create a set of tests to prove the delivered MMIS meets or exceeds each of the criteria identified.

C.5.7.3.3 Execute the tests and make corrections to the MMIS until all tests demonstrate compliance.

C.5.7.3.4 Create a catalog of all overviews, diagrams, data models, system documentation, reports and any other materials necessary to present during the CMS audit for MMIS certification.

C.5.7.3.5 Identify qualified staff members, including a certification manager, to defend the certification, to explain all prepared materials and reports to the District and CMS representatives, and to assist the District during the certification process.

C.5.7.3.6 Conduct a certification demonstration to the District to walk through all of these prepared materials.

C.5.7.3.7 Issue a formal, written statement indicating the system has all capabilities required for federal MMIS certification.

C.5.7.3.8 Complete all these activities before implementation begins.

C.5.8 ELECTRONIC MAIL/COURIER SERVICE

C.5.8.1 All Contractor staff shall have secure electronic mail (e- mail) capability through the Internet that will allow for the sharing of files from the currently installed version of the Microsoft Office Suite at the District for corresponding with the MAA staff.

C.5.8.2 For communications that cannot be sent via electronic mail and report delivery, the Contractor shall provide courier service to and from the MAA facilities twice each day. One courier service run shall be in the morning and one in the afternoon. Delivery at the District sites - the Contractor's courier shall make delivery to each MAA functional unit.

C.5.9 MMIS OPERATIONS

The Contractor shall be responsible for the operation of the MMIS after completion of the system implementation. The District requires that the Contractor provide suitably qualified personnel, equipment resources, facilities, and supplies necessary to support the production and operation of the MMIS and also meet the requirements and performance standards described in this RFP.

C.5.9.1 Production Operations Support

C.5.9.1.1 Production operations support includes the managerial and technical services required to manage and operate the MMIS. Specific requirements include scheduling and monitoring batch production runs, including actively participating in the scheduled production meetings, facilitating LAN and WAN connectivity for the MMIS, administering the database, and performance tuning.

C.5.9.1.1.1 The Contractor shall provide all services associated with Production Operations Support including the following activities:

(a) Batch cycle scheduling specifications, including job turn-around time monitoring and problem resolution;
(b) Database administration;
(c) Problem identification and resolution;
(d) Software release and emergency implementation; Change Management and Version Management;
(e) System resource forecasting;

(f) Response time monitoring and problem resolution;
(g) Software migration;
(h) Contractor's LAN support and administration;
(i) MMIS security implementation and monitoring;
(j) Daily, weekly, and monthly production status reporting;
(k) Mainframe liaison support with ISD; and
(l) All other activities required meeting the requirements and the performance specifications of the contract.

C.5.10 Operational Trouble Reports

Upon the Contractor's discovery of any problem that may jeopardize the successful or timely completion of its obligations, the Contractor shall notify the COTR orally and via fax and email. The oral notification shall be no later than the close of business of that day if the problem is discovered before 4:30 p.m. If the problem is discovered after 4:30 p.m. or on a non-business day, notification shall occur no later than 8:30 a.m. on the succeeding business day. The Contractor shall follow the oral notification with a written analysis within one (1) business day. The written analysis shall be sent to the COTR and shall include a recommendation for expeditious resolution of the problem. Where the operational problem results in delays in report distribution or problems in on-line access on state business days, the Contractor shall notify the COTR, and the MAA Help Desk during business hours, within fifteen (15) minutes of discovery of the problem, in order for state work activities to be rescheduled.

C.6 MMIS FUNCTIONAL SUBSYSTEM REQUIREMENTS

The MMIS must receive, enter, process, adjudicate to payment or denial, and report on claims submitted by providers for services rendered to Medicaid eligible recipients. It must ensure the accuracy, reasonableness, and integrity of the claims processing function and meet District of Columbia's information retrieval needs.

The MMIS functional requirements are presented here for the purpose of assisting Contractors in gaining an understanding of District of Columbia's needs in obtaining a replacement MMIS.

This subsection presents descriptions of the requirements for each of the following MMIS subsystem functions:

1. Recipient Data Maintenance;
2. Provider Data Maintenance;
3. Reference Data Maintenance;
4. Prior Authorization (PA) Processing;
5. Claims Control;
6. Claims Entry;
7. Edit/Audit Processing;

8. Claims Pricing;
9. Claims Correction;
10. Claims Operations Management;
11. Financial Processing;
12. Third-Party Liability (TPL) Processing;
13. Long Term Care (LTC) Processing;
14. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Processing;
15. Quality Control/Assurance;
16. Management and Administrative Reporting (MARS);
17. Surveillance and Utilization Review (SUR);
18. Home and Community Based Care (HCBC) Processing;
19. Clinical Laboratory Improvement Act (CLIA) Support;
20. HMO and Enrollment Broker Interface;
21. Transportation Broker Interface;
22. Drug Rebate Processing; and
23. Drug Utilization Review (DUR).

For each of the above functions, an overview is presented first, followed by a description of s using the following subheadings:

1. Inputs,
2. Processing Requirements,
3. Information Retrieval, and
4. Interfaces.

In addition to supporting the requirements listed below, the new MMIS shall provide for the following capabilities across all functional areas of the system.

(a) Maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times. This graphical user interface shall not, in any part, consist of what is commonly known as 'screen scraped' presentations of the output of the transferred system. The District is not interested in a legacy system that passes data from existing screen displays to server or PC based applications to reformat the data in a Windows environment.

(b) Provide for contact sensitive help on screens for easy "point and click" access to valid values and code definitions by screen field.

(c) Maintain flexibility in programming coding structures by use of parameter and table oriented design techniques.

(d) Provide data from the functional areas to the DSS/DW, Safe Passages Integration System (SPIS) and Web Portal.

(e) Provide reports in data format for export and import purposes and through multiple media including paper, imaging, CD-ROM, electronic file, microform, diskette, and tape cartridge.

C.6.1 RECIPIENT DATA MAINTENANCE

The primary purpose of the Recipient Data Maintenance function is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for District of Columbia medical assistance and to support analysis of the data contained within the recipient data maintenance system. The maintenance of recipient data is required to support claim processing in both batch and online mode, reporting functions and eligibility verification. Other functions that address recipient-specific data are TPL processing (C.6.12), LTC processing (C.6.13), and EPSDT processing (Subsection C.6.14). The current source of eligibility data for the MMIS is a daily file extract from the District-operated Automated Client Eligibility Determination System (ACEDS) administered by Income Maintenance Administration (IMA). IMA serves as the District's eligibility system for all District welfare programs and generates Medicaid eligibility identification cards used by recipients to gain access to health care providers.

The principle objectives of the recipient data maintenance function of the MMIS are to:

1. Maintain identification of all recipients eligible for Medical assistance benefits;
2. Accept timely updates of the recipient file(s) to include new recipients and all changes to existing recipient's data;
3. Maintain and ensure positive control over the recipient eligibility data required to process claims and meet District and Federal reporting requirements; and
4. Provide the recipient-related data for the recipient Eligibility Verification System (EVS), managed care Enrollment Broker and Transportation Broker.

C.6.1.1 Inputs

The Recipient Data Maintenance function will accept input from various sources to add, change, or close records on the recipient file(s). Inputs to the Recipient Data Maintenance function include:

1. The IMA;

2. Transportation and HMO enrollments and changes from the broker;
3. Beneficiary Data Exchange (BENDEX) tape; and
4. On-line update transactions for recipient special programs such as lock-in restriction, HMO enrollment, long term care, and waivers.

C.6.1.2 Processing Requirements

The District of Columbia MMIS Recipient Data Maintenance function shall have the following system capabilities in order to meet the District's objectives for recipient data maintenance. It shall have the capabilities to:

C.6.1.2.1 Maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

C.6.1.2.2 Collect and accept a file of recipient data from the IMA, in an agreed upon format and media, on a daily basis.

C.6.1.2.3 Perform any necessary reconciliation of the MMIS recipient file to the IMA.

C.6.1.2.4 Edit data transferred from the IMA for completeness and consistency, according to edit criteria established by the District.

C.6.1.2.5 Identify potential duplicate recipient records during update processing.

C.6.1.2.6 Maintain on-line access to 5 years of historical recipient information, with inquiry capability by recipient ID number, name or partial name, and the ability to use other factors such as date of birth and/or Social Security number to limit the search by name.

C.6.1.2.7 Maintain identification of recipient eligibility in special eligibility programs, such as waiver, HMO, transportation broker, case-management, and other medical assistance programs, with effective dates and other data required by the District.

C.6.1.2.8 Maintain current and historical date-specific eligibility data for basic program eligibility, special program eligibility, and all other recipient data required to support claims processing, prior authorization processing, eligibility verification processing, and reporting.

C.6.1.2.9 Maintain reason codes for eligibility termination.

C.6.1.2.10 Provide update capability, to add, change, or delete recipient lock-in restriction data such as, restriction type, provider number, and effective dates.

C.6.1.2.11 Maintain flexibility in coding structures, such as recipient aid categories and program identifiers, to support changes to claims processing and reporting requirements.

C.6.1.2.12 Maintain an adequate history of HMO enrollment including the ability to automatically assign a recipient that is qualified for Provider Continuity.

C.6.1.2.13 Edit, and transmit acceptance or rejection of, enrollment broker maintenance transactions.

C.6.1.2.14 Maintain an adequate history of Transportation Broker including the ability to automatically assign a recipient that is qualified.

C.6.1.3 Information Retrieval

At a minimum, the proposed system shall be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information shall be made available in report format, on-line, or through another medium specified by the District.

C.6.1.3.1 The following types of reports shall be available from the Recipient Data Maintenance function:

1. Reports to meet all Federal and District reporting requirements,
2. Active/inactive recipient summary listings,
3. Possible duplicate recipient list,
4. Enrollment broker maintenance activity reports,
5. Transportation Broker recipient listings,
6. Recipients auto-assigned to an HMO,
7. Recipients who have changed name during month,
8. Audit trail and error reports of on-line updates, and
9. Control reports of daily/weekly file updates and file reconciliation.

Additional output requirements for the Recipient Data Maintenance function include:

C.6.1.3.2 Provision of the most current recipient data available for the support of the eligibility verification and HMO enrollment functions.

C.6.1.3.3 On-line inquiry screens which will accommodate the following, using a minimal number of screens:

1. Recipient basic demographic data;
2. Recipient current and historical eligibility data;
3. LTC enrollment data with appropriate Patient Liability;
4. BUYIN and BENDEX data;
5. Lock-in to Waiver Programs that includes Transportation lock-in;

6. Recipient special program and restriction data; and
7. Recipient managed care enrollment data.

C.6.1.4 Interfaces

The Recipient Data Maintenance function shall include system interfaces with the following:

1. Income Maintenance Agency (IMA),
2. Data Warehouse and Web Portal,
3. Enterprise Medicaid Web Portal,
4. Drug POS Contractor,
5. Transportation Broker,
6. Common work file (BENDEX SSA file),
7. Eligibility Verification System (EVS),
8. Enrollment Broker, and
9. Safe Passages Integration System (SPIS)

C.6.1.5 ELIGIBILITY VERIFICATION SYSTEM

The purpose of the Eligibility Verification System is to provide an efficient and effective method for its provider community and other MMIS users to verify recipients' eligibility, third party insurance information, managed care provider information, spend down data and any other eligibility restriction data. In addition, this function is to allow providers to inquire and request information on prior authorization status and to request claims histories and remittance advices via telephone or standard transactions X12N format.

C.6.1.5.1 Inputs

The MMIS Eligibility Verification System function shall accept the following inputs:

(a) The most current recipient data available,
(b) The most current MMIS provider data available,
(c) Inquiries from providers and authorized district personnel via personal computers (PCs) and point-of-sale (POS) devices, and
(d) Telephone inquiries from providers and authorized District personnel.

C.6.1.5.2 Processing

The MMIS Eligibility Verification System function shall have the following processing capabilities:

C.6.1.5.3 Maintain a toll- free, dial- up, access, for enrolled medical providers, located within the state and out of state, through the use of their touch-tone telephones, through the public switched telephone network, to the MMIS Eligibility Verification System.

C.6.1.5.4 Maintain a dial- up access, for enrolled medical providers through use of PCs and their "switch vendors" (Envoy, National Data Corporation, and any other network provider utilized), to the MMIS Eligibility Verification System.

C.6.1.5.5 Maintain access to the MMIS Eligibility Verification System for the enrolled provider community. The provider community will access these Contractor maintained systems through the use of their own or leased equipment and services provided by "switch vendors" (Envoy, National Data Corporation, and any other network provider utilized). The Contractor shall allow and maintain the switch vendors' access to these systems.

C.6.1.5.6 Maintain a dial- up access, for enrolled medical providers through use of point-of-sale devices through the public switched telephone network, to the MMIS Eligibility Verification System.

C.6.1.5.7 Maintain a secured, password protected, Internet access, for enrolled medical providers through use of their PCs or other Internet devices and their authorized Internet service provider, to the Eligibility Verification System.

C.6.1.5.8 Maintain an interactive, Eligibility Verification System session, through the use of MMIS Eligibility Verification System that accepts and sends HIPAA compliant EDI formats and meets draft MAA security, confidentiality and privacy requirements and HIPAA and other federal security, confidentiality and privacy requirements. These HIPAA requirements are requested to be as part of the solution for this RFP.

C.6.1.5.9 Maintain a recipient eligibility session, that minimally communicates the following:

a) Provides the appropriate safeguards, including:

1. Limiting access to eligibility information to authorized medical providers and authorized state personnel only; and
2. Protecting the confidentiality of all recipient information.

b) Maintaining an audit trail of all inquiries and verification responses made, the information conveyed, and to whom the information was conveyed;

c) allowing inquiry by case number, inquiry by full name and date of birth, inquiry by partial name and date of birth, and inquiry by social security number (SSN) and date of birth;

d) validating that an active recipient identification card is presented based on the card issue date; and

e) limits access to eligibility verification inquiry to inquire for dates of service within the preceding thirteen months.

C.6.1.5.10 Provide on-line access for inquiry to all audit trail data regarding eligibility verification inquiries.

C.6.1.5.11 Provide the capability for providers to request the status of prior authorizations required, for a date or date range or by procedure code, for a recipient, through dial-up access, their PC, and "switch vendor" software and network, and through the internet to a web enabled application and for the MMIS Eligibility Verification System to respond with the prior authorization information.

C.6.1.5.12 Provide the capability for providers to request remittance advice and claims histories through dial-up access, their PC, and "switch vendor" software and network and through the Internet via a web enabled application and for the MMIS Eligibility Verification System to respond with the remittance advice and/or claims history.

C.6.1.5.13 Charge the provider according to District allowed amounts per page for all remittance advice and claim history requests that are requests for paper copies.

C.6.1.5.14 Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.6.1.5.15 Maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times.

C.6.1.5.15 Provide for context-sensitive help on screens for easy, "point and click" access to valid values and code definitions by screen field.

C.6.1.5.14 Edit all data for presence, format, and consistency with other data in all eligibility verification processing.

C.6.1.5.14 Maintain password control, in varying levels of security, of staff making changes to eligibility verification data.

C.6.1.6.1 Outputs

The MMIS Eligibility Verification System function shall provide the following outputs and support the following information needs:

C.6.1.6.2 All data shall be available for retrieval through the DSS/DW function.

C.6.1.6.3 The Contractor shall make available all reports in data format for export and import purposes and through multiple media including paper, CD-ROM, electronic file, microform, diskette, and tape cartridge.

C.6.1.6.4 The following types of reports shall be available according to District specific criteria:

(a) Reports to meet all federal and state reporting requirements;
(b) Operational reports about the number of inquiries received during the month, average waiting time for inquiries by hour segment, by day;
(c) Operational reports about the average response time of inquiries received during the week and month, average response time for inquiries by hour segment, by day, by week, by month;
(d) records of what information was conveyed, and to whom, by week;
(e) System downtime;
(f) Counts of inquiries by provider type and individual providers; and
(g) Appropriate reports to analyze and monitor usage of the Eligibility Verification System function by access method, and to support measurement of performance expectations.

C.6.1.6.5 The primary output of the Eligibility Verification System function is the recipient eligibility data provided to providers for confirming recipient eligibility for District Medical Assistance Program services. This function also provides responses concerning prior authorizations, claims histories and remittance advises.

C.6.1.6.6 Provide the on- line screens for the Eligibility Verification System function to support the access to inquiry histories and responses by inquirer ID, type of inquiry, date of inquiry, date of service related to the inquiry, or a combination thereof.

C.6.1.6.7 Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.6.1.6.8 Interfaces

The Eligibility Verification System function shall accommodate an external interface with:

(a) provider to provider "switch vendor" telephone systems,
(b) provider switch vendor's telecommunication lines, and the Internet.

C.6.1.7 Managed Care

The Managed Care function is designed to assure recipient access to necessary medical care, while at the same time controlling medical assistance program costs. Under such models, the state has developed a network of MCOs who are contracted to provide medical services to Medicaid program recipients. Recipients receive services covered under the specific capitated plan from the managed care organization. In addition, recipients receive certain carve out services outside of the managed care plan.

The objectives of the District's managed care program are:

(a) Increased recipient access to healthcare,
(b) Increased use of case management and preventive services, and
(c) Optimal patient outcomes.

C.6.1.7.1 Inputs

The MMIS Managed Care Processing function shall accept the following inputs:

(a) Managed care organization (MCO),
(b) Provider eligibility data from the provider data maintenance function,
(c) Electronic file of updates for recipient managed care plan and Primary Care Physician choices (PCP) and from the enrollment broker,
(d) Claim data from the financial function for claims paid for kick payments or incentive payments,
(e) Recipient managed care enrollment data from the recipient data maintenance function,
(f) Encounter data in the form of "shadow claims" in HIPAA standard format from MCOs,

(g) Claim data from the financial function for claims paid for capitation payment to MCOs,
(h) Claim data from the financial function for claims paid as fee- for service for recipients in managed care having services outside those covered by the specific managed care plan(s) they are enrolled with, and
(i) Reference data from the reference data maintenance function.

C.6.1.7.2 Processing

The MMIS Managed Care Processing function shall have the following processing capabilities:

C.6.1.7.2.1 Maintain on- line access to all recipient, providers, encounter (shadow claims), reference data related to managed care.

C.6.1.7.2.2 Provide and maintain flexibility in coding structures by use of parameter and table oriented design techniques to enable rapid processing modifications in order to support DC Medicaid care program changes.

C.6.1.7.2.3 Maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times.

C.6.1.7.2.4 Provide for context-sensitive help on screens for easy "point and click" access to valid values and code definitions by screen field.

C.6.1.7.2.5 Maintain managed care related recipient data in the recipient data maintenance function including recipient's geographic location based on longitude and latitude.

C.6.1.7.2.6 Accept and process on- line recipient enrollment/dis-enrollment to managed care models on a day-specific basis.

C.6.1.7.2.7 Provide the ability to associate managed care recipients with the managed care plans in which they are enrolled.

C.6.1.7.2.8 Provide the ability to lock- in and lock-out recipients to managed care plans.

C.6.1.7.2.9 Update automatic assignment of recipients, when they have not made a choice, to managed care models and plans based on the Enrollment Broker criteria.

C.6.1.7.2.10 Provide the ability to update managed care plan assignments/choices on- line.

C.6.1.7.2.11 Accept and process retroactive enrollment and disenrollment of recipients to all managed care models.

C.6.1.7.2.12 Capture, store, and retrieve date-specific, recipient-specific managed care enrollment history.

C.6.1.7.2.13 Incorporate the Managed Care Enrollment Broker system and related system processes in the MMIS and the operations of the MMIS. The Managed Care Enrollment Broker, not the Contractor, will continue to perform the actual enrollment process.

C.6.1.7.2.14 Indicate manual and auto-enrollments of recipients to managed care plans, assign managed care plan enrollment by recipient choice, and assign managed care plan enrollment by default (no recipient response), indicating who made the choice by default.

C.6.1.7.2.15 Provide for multiple payment methods to support managed care including:

(a) Capitated payment for a group of covered services within a plan and fee-for service payment for covered services outside any plan the recipient is enrolled with; and
(b) Payment of kick and incentives fees to an assigned managing provider and fee-for service payments for services.

C.6.1.7.2.17 Maintain managed care provider-related data including capitation rates for specific groups of recipients for each managed care provider and weight of automatic assignment.

C.6.1.7.2.19 Calculate and generate capitated payments to participating managed care organizations whose pricing is based on a capitation payment model and automatically process adjustments/recoupments. Capitation payment shall be pro-rated to the days the recipient is enrolled with the managed care provider in the given payment period.

C.6.1.7.2.20 Provide the ability to pay capitated payments at provider specific rates based on recipient demographics including eligibility program, place of residence, age, sex, and risk factors.

C.6.1.7.2.22 Accept and process recipient health risk assessment data and determine risk factors.

C.6.1.7.2.23 Provide the ability to apply edits/audits that prevent claims from being paid when managed care program recipients receive plan covered services from sources other than the capitated plans in which they are enrolled.

C.6.1.7.2.24 Provide the ability to apply edits/audits that prevent claims from being paid when they have not received a referral or authorization as may be required by the managed care plan with whom they are enrolled.

C.6.1.7.2.25 Provide the ability to identify, edit, and correctly adjudicate fee-for-service claims for services not covered by a specific managed care plan.

C.6.1.7.2.26 Provide the ability to receive, process (edit and price), and report on encounter data in the form of shadow claims for managed care recipient enrollees.

C.6.1.7.2.27 Provide the ability to perform basic edits on these shadow claims to ensure integrity and allow for the pricing of these shadow claims.

C.6.1.7.2.28 Provide methodology to track the utilization rates for program enrollees and to compare such utilization rates to comparable groups of non-managed care recipients and across different managed care plans, to assure sufficient savings are achieved.

C.6.1.7.2.29 Capture and process encounter data for use in utilization/quality assurance reporting (HEDIS), other national and/or relevant healthcare qualities benchmarks and measures, and other capitation rate setting purposes.

C.6.1.7.2.31 Capture, store, and retrieve, managed care provider-related data for all managed care models.

C.6.1.7.2.34 Generate electronic roster updates daily and monthly paper summary rosters for all MCOs.

C.6.1.7.2.37 Generate electronic encounter data remittance advices that include the HIPAA transaction.

C.6.1.7.2.38 Provide for web-enabled communication for delivery capitation and encounter RAs to managed care plans. The web-enabled Managed Care Roster and Remittance Advice delivery system must send HIPAA compliant EDI formats and meet District security, confidentiality and privacy requirements and HIPAA and other federal security, confidentiality and privacy requirements.

C.6.1.7.2.39 Allow for the payment of capitated rates on a daily pro-rated basis based on the day the recipient is enrolled.

C.6.1.7.2.40 Provide for monthly capitated payments and weekly payment for newly enrolled recipients.

C.6.1.7.2.41 Perform automated adjustments and recoupments of capitated payments.

C.6.1.7.2.42 Provide the capability for "risk adjustment" payment methodologies using state or industry defined criteria. Establish "Risk Pools" to allow for payment hold backs and/or incentive payments.

C.6.1.7.2.43 Allow for the merging of the Medicaid and Medicare payment stream.

C.6.1.7.2.44 Update rules-based auto assign and recipient choice enrollment, operating with multiple layers of managed care models given by the Enrollment Broker.

C.6.1.7.2.48 Provide the ability for the managed care interface for viewing, uploading and downloading, on a daily and monthly basis, recipient rosters via a secured, password protected web site. The web-enabled Managed Care interface shall accept and send HIPAA compliant EDI formats and meet the District security, confidentiality and privacy requirements and HIPAA and other federal security, confidentiality and privacy requirement.

C.6.1.7.2.49 Process daily, the rosters that managed care providers have uploaded to the web site updating recipient selections/assignments.

C.6.1.7.2.50 Maintain an on- line audit trail of all updates to managed care data.

C.6.1.7.2.51 Edit all data for presence, format, and consistency with other data in the update transaction and on all managed care processing and data related tables.

C.6.1.7.2.52 Maintain password control, in varying levels of security, of staff making changes to managed care data.

C.6.1.7.2.53 Provide on- line, updateable letter templates for recipient, provider or submitter/biller letters with the ability to add free form text specific to a recipient, provider or submitter/biller.

C.6.1.7.2.54 Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.6.1.7.3 Outputs

The MMIS Managed Care function shall provide the following outputs and support the following information needs:

C.6.1.7.3.1 All data shall be available for retrieval through the DSS/DW function.

C.6.1.7.3.2 All reports shall be made available in data format for export and import purposes and through multiple media including paper, CD, DVD, electronic file, microfilm, diskette, imaging and tape cartridge.

C.6.1.7.3.3 Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.6.1.7.3.4 The following types of reports shall minimally be available:

(a) All federal and state required reports including those needed to support the 1115A waiver;

(b) Amount and type of services provided by capitated plans to enrolled recipients, as reported on encounter forms;
(c) Numbers of services paid outside each plan;
(d) Managed care enrollees by source of their enrollment;
(e) Total medical assistance expenditures for managed care recipients versus non managed care expenditures by program and eligibility category;
(f) Identification of recipients who are eligible but not enrolled in managed care and those recipients who are not eligible to be enrolled but have been assigned to a MCO;
(g) A detailed list of all Managed Care providers;
(h) By health plan of open prior authorizations for recipients newly enrolled to managed care;
(i) Managed care enrollment statistics;
(j) Encounter data remittance advices provided to managed care providers;
(k) Managed care rosters for all health plans that contain related recipient data in the recipient data maintenance function including an indicator for recipients certified as members of recognized Indian tribes; all TPL information; and recipient profile information including, language spoken, handicap access needed, health status identifying specialized medical needs (including any open prior authorizations, and recipient risk assessment data); and
(l) Notices/letters to recipients.

C.6.1.7.3.5 Provide the on- line screens so that the Managed Care function can assure recipient access to necessary medical care, while at the same time controlling medical assistance program costs.

C.6.1.7.4 Interfaces

The MMIS Managed Care function shall accommodate an external interface with:

(a) The internet and the State LAN for managed care providers, to send rosters with recipient TPL data and encounter data remittance advices, and accept encounter data for this function;
(b) The district eligibility system; and
(c) The enrollment broker.

C.6.2 PROVIDER DATA MAINTENANCE

The Provider Data Maintenance function maintains comprehensive current and historical information about providers eligible to participate in the District of Columbia Medicaid program. Through the establishment of a single provider master file, provider demographic, certification, rate, and summary financial information is maintained to support accurate and timely claims processing, enhanced management reporting, and utilization review reporting and surveillance activities.

The District of Columbia MMIS Provider Data Maintenance function objectives are to:

1. Encourage the participation of qualified providers in the District of Columbia medical assistance program by making enrollment and re-enrollment an efficient process;
2. Process provider applications and changes in a timely manner;
3. maintain control over all provider data; and
4. Maintain all demographic and rate information to support claims processing and reporting functions.

In the District of Columbia, each provider has a unique medical assistance provider number that is assigned by the MMIS system.

C.6.2.1 Inputs

The inputs to the Provider Data Maintenance function include:

1. Provider enrollment and application forms,
2. Provider update transactions,
3. Changed provider information from the District,
4. Provider inquiries, and
5. Financial payment and accounts receivable data from the Financial Processing function.

C.6.2.2 Processing Requirements

The Provider Data Maintenance function shall have the capabilities to:

C.6.2.2.1 Send provider enrollment applications to providers who request them, within two (2) work days.

C.6.2.2.2 Forward provider enrollment packages to MAA for review and approval.

C.6.2.2.3 Accept adds and changes to the provider master file through on-line, real-time terminal entry.

C.6.2.2.4 Maintain a function to deactivate all provider records meeting specific MAA criteria (for example, no provider billing for two [2] years, license expiration).

C.6.2.2.5 Edit all terminal-entered data for presence, format, and consistency with other data in the update transaction and on the provider master file.

C.6.2.2.6 Edit to prevent duplicate provider enrollment during an add transaction.

C.6.2.2.7 Identify and report any duplicate provider numbers, license or certification numbers, SSN, or FEIN numbers on the provider master file.

C.6.2.2.8 Accept and store the Medicare Universal Provider Identification Number (UPIN), National Provider Identifier (NPI).

C.6.2.2.9 Monitor provider enrollment to ensure that each provider only has one provider number.

C.6.2.2.10 Cross-reference inactive provider numbers (including old and new numbers), which would identify the current active number for that entity.

C.6.2.2.11 Maintain an audit trail of provider name, provider number (including old and new numbers), or status changes.

C.6.2.2.12 Maintain on-line access to a minimum of twenty-seven (27) months of historical provider information, including provider rates and effective dates, provider program and status codes, and summary payment data.

C.6.2.2.13 Maintain on-line access to the provider master file with inquiry by provider name, provider number, tax ID, UPIN, NPI, or group number.

C.6.2.2.14 Maintain the provider name on the provider master file as one continuous field for company names and as Last, First, MI and Title for individuals; with the capability to sort individuals by last name.

C.6.2.2.15 Maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

C.6.2.2.16 Identify by provider any applicable type code, location code, practice type code, category of service code, and medical specialty code which is used in the District of Columbia medical assistance Program, and which affects provider billing, claim pricing, or other processing activities.

C.6.2.2.17 Provide for identification of sufficient numbers of provider type codes to accommodate current and future needs of the Program (potentially up to 100 of any one kind of provider type code may be needed).

C.6.2.2.18 Maintain effective dates for provider group membership, enrollment status, EMC billing data, restriction and on-review data, certification(s), specialty, claim types, and other user-specified provider status codes and indicators. The certification and specialty will only be put on the individual records of the service provider. No specialty or provider type should be assigned on the group provider number.

C.6.2.2.19 Accept on-line, real-time updates of review or restriction indicators and dates on a provider's record to assist MAA in monitoring a provider's medical practice.

C.6.2.2.20 Accept group provider numbers, and relate individual providers to their groups, as well as a group to its individual member providers, with effective dates. A single group provider record must be able to identify up to 500 individuals who are associated with the group.

C.6.2.2.21 Identify the entity through which a provider bills, if a billing service is used.

C.6.2.2.22 Identify providers that use automated submittal of claims, automated remittances, and/or automated funds transfer in claims processing.

C.6.2.2.23 Maintain multiple, provider-specific reimbursement rates, including per diems, rates based on levels of care or other cost containment initiatives, with beginning and ending effective dates for a minimum of 36 segments, with on-line, real-time update capability.

C.6.2.2.24 Maintain managed care capitation rates by HMO and rate ID with effective begin and end dates for a period of 60 months.

C.6.2.2.25 Identify multiple practice locations where services were rendered for a single provider.

C.6.2.2.26 Maintain multiple addresses for a provider, including:

1. Pay to,
2. Mail to, and
3. Service location(s).

C.6.2.2.27 Maintain the number of beds and level of care, in addition to other District-specified data elements with a minimum of 36 date-specific segments for long-term care facilities (for example, NF, SNF, ICF-MR) and other institutional providers (for example, inpatient).

C.6.2.2.28 Maintain all existing provider enrollment status codes with associated date spans.

C.6.2.2.29 Maintain specific codes for restricting the services for which providers may bill to those for which they have the proper certifications (for example, lab certification codes).

C.6.2.2.30 Maintain the flexibility to accommodate non-medical providers on the provider master file (for example, non-medical case managers, school districts), and maintain the necessary data on such providers.

C.6.2.2.31 Perform mass updates to provider rate information at District direction.

C.6.2.2.32 Accept retroactive rate adjustments to the provider file.

C.6.2.2.33 Maintain summary-level accounts receivable and payable data in the provider file which automatically updated after each claims processing payment cycle by calendar and District fiscal year-to-date totals.

C.6.2.2.34 Maintain the flexibility to change provider types, specialties, categories, and convert history records to reflect new provider type categories.

C.6.2.2.35 Maintain the capability to identify agency or department funding source based on provider type or specialty.

C.6.2.3 Information Retrieval

At a minimum, the proposed system shall be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information shall be made available in report format, on-line, or through another medium as specified by the District. All on-line provider screens shall display basic identifying provider information including name and number. The system shall provide:

C.6.2.3.1 Reports to meet all Federal and District reporting requirements.

C.6.2.3.2 Enrollment approval/denial letters.

C.6.2.3.3 Report showing status of provider applications in process.

C.6.2.3.4 Group mailings and provider labels based on selection parameters such as provider type, category of service, specialty, county, and special program participation.

C.6.2.3.5 List of providers to be deactivated/purged due to inactivity.

C.6.2.3.6 Alphabetic and numeric provider listings that can be generated by selection parameters such as provider type, category of service, specialty, and enrollment status.

C.6.2.3.7 A summary report of adds and changes to provider file data.

C.6.2.3.8 On-line information showing provider eligibility history.

C.6.2.3.9 Provider cross-reference listings for SSN and license numbers.

C.6.2.3.10 Report that displays growth in the number of active providers by provider type and specialty over time.

C.6.2.3.11 Report identifying providers who have changed practice arrangements (for example, from one group practice to another) by provider type.

C.6.2.3.12 On-line information showing all rendering providers associated with a group, and all groups with whom a rendering provider is associated, for user defined time periods.

C.6.2.3.13 Provider 1099 statements and associated payment reports.

C.6.2.3.14 Reports and on-line information required for institutional rate setting.

C.6.2.3.15 Basic information about a provider displayed on a single screen (for example, name, location, number, provider type, specialty, certification dates, and so forth).

C.6.2.3.16 License renewal required and expired.

C.6.2.3.17 Provider accounts receivable and payable data.

C.6.2.3.18 Additional provider information, such as provider addresses, group data, and summary calendar and District YTD claims submittal and payment data.

C.6.2.3.19 For institutional providers, the number of beds in the facility and reimbursement rates.

C.6.2.3.20 On-review data, special data (for example, lab certification data).

C.6.2.4 Interfaces

The Provider Data Maintenance function must accommodate interface needs with the following:

1. HMO Enrollment Broker,
2. Medicaid Web Portal,
3. Drug POS Contractor, and
4. Data Warehouse.

C.6.3 REFERENCE DATA MAINTENANCE

The Reference Data Maintenance function maintains pricing files for procedures and drugs, and maintains other general reference information such as diagnoses, edit/audit criteria, edit dispositions, and error and remittance text information. It provides a consolidated source of reference information that is accessed by the MMIS during performance of other functions, including all claims processing functions, Prior Authorization and TPL processing, and the Management and Surveillance and Utilization Review reporting functions.

The District's goals in the maintenance of reference data are to:

1. Provide coding and pricing verification during claims processing for all approved claim types and reimbursement methodologies, and

2. Maintain flexibility in reference parameters and file capacity to make the MMIS capable of accommodating changes in the Medical assistance program.

C.6.3.1 Inputs

The inputs to the Reference Data Maintenance function are:

1. District-approved updates for procedure, drug, diagnosis, edit/audit criteria, and edit disposition files;
2. Bi-weekly updates from a contracted drug pricing service for drug codes and prices;
3. CMS - HCPCS updates; and
4. ICD-9 diagnosis and procedure updates.

C.6.3.2 Processing Requirements

The Reference Data Maintenance function shall comply with the following requirements in order to support the MMIS processing functions. It shall be able to:

C.6.3.2.1 Accept and maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

C.6.3.2.2 Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.

C.6.3.2.3 Accept District submitted on-line and batch updates, additions, and deletions to all reference files, including changes to individual records or mass changes to groups or classes of records.

C.6.3.2.4 Maintain password control of staff making changes to reference data.

C.6.3.2.5 Maintain a Procedure data set which contains the five-character HCPCS code for medical-surgical and other professional services, ADA dental codes; a two-character field for HCPCS pricing modifiers; and District of Columbia specific codes for other medical services; the Procedure data set will contain, at a minimum, the following elements:

1. Eight (8) date-specific pricing segments, including a pricing action code and allowed amount for each segment;
2. District-specified restrictions on conditions to be met for a claim to be paid including, but not limited to: provider type, specialty, lab certification, recipient age/sex restrictions, prior authorization required, place of service, type of service, appropriate diagnosis, units of service, and the like;
3. Multiple modifiers and the percentage of the allowed price applicable to each modifier;

4. Narrative descriptions of procedure codes in both medical terminology and lay language;
5. Indication of non-coverage by third party payers;
6. Other information such as accident-related indicators for possible TPL, Federal cost-sharing indicators, Medicare coverage and allowed amounts; and
7. PA required.

C.6.3.2.6 Maintain a Diagnosis data set utilizing the three- (3-), four- (4-), and five- (5-) character ICD-9-CM coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:

1. Age,
2. Sex,
3. Family planning indicator,
4. Prior authorization,
5. Trauma diagnosis and accident cause codes,
6. Description of the diagnosis, and
7. Primary and secondary diagnosis code usage.

C.6.3.2.7 Maintain English language descriptions of diagnoses.

C.6.3.2.8 Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the potential implementation of ICD-10, without additional costs to the District.

C.6.3.2.9 Maintain a Drug data set of the eleven (11) digit National Drug Code (NDC), which can accommodate updates from an updating service; the Drug data set shall contain, at a minimum:

1. Eight (8) date-specific pricing segments which include all prices and pricing action codes needed to adjudicate drug claims in accordance with District policy;
2. Indicator for multiple dispensing fees;
3. Indicator for drug rebate including name of manufacturer;
4. District-specified restrictions on conditions to be met for a claim to be paid including but not limited to minimum/maximum days supply, quantities, refill restrictions, recipient age/sex restrictions, medical review requirements, prior authorization requirements, place of service, and the like;
5. Description of the drug code;
6. Identification of the therapeutic class;

7. Identification of strength, units, and quantity on which price is based; and
8. Indication of DESI status (designated as less than effective), and IRS status (identical, related or similar to DESI drugs).

C.6.3.2.10 Maintain a Revenue Code data set for use in processing claims for inpatient and outpatient hospital services.

C.6.3.2.11 Maintain flexibility to accommodate multiple reimbursement methodologies, including DRG reimbursement for inpatient hospital care.

C.6.3.2.12 Maintain an Edit/Audit Criteria table to provide a user-controlled method of implementing service frequency, quantity limitations, and service conflicts for selected procedures and diagnoses, with on-line update capability.

C.6.3.2.13 Provide the on-line capability to place edit/audit criteria limits on types of service by procedure code, revenue code, diagnosis codes, and drug class, based on:

1. Recipient age, sex, eligibility status;
2. Diagnosis;
3. Provider type, specialty;
4. Place of service;
5. TPL;
6. Tooth and surface codes;
7. Floating or calendar year period; and
8. Months or days periods.

C.6.3.2.14 Maintain a user-controlled Claim Edit Disposition data set with disposition information for each edit used in claims processing, including the disposition (pay, suspend, pay and report, deny) by submission medium within claim type, the description of errors, and the related Explanation of Medical Benefits (EOMB) codes, with on-line update capability.

C.6.3.2.15 Maintain a user-controlled remittance and message text data set with access by edit number, showing the remittance advice message for each error and the EOMB messages, with on-line update capability.

C.6.3.3 Information Retrieval

At a minimum, the proposed system must be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information must be made available in report format, on-line, or through another medium as specified by the District. To support the Reference Data Maintenance function the system must:

C.6.3.3.1 Maintain on-line access to all Reference files with inquiry by the appropriate code, depending on the file or table being accessed.

C.6.3.3.2 Maintain on-line inquiry to procedure and diagnosis files by key alpha name.

C.6.3.3.3 Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.6.3.3.4 Generate listings of the Procedure, Diagnosis, Drug, Revenue Code, Medical Criteria, Usual and Customary Charge, and other files based on variable, user-defined select and sort criteria.

C.6.3.3.5 Provide inquiry screens that display:

1. All relevant pricing data and restrictive limitations for claims processing, and
2. All pertinent data for claims processing and report generation.

C.6.3.4 Interfaces

The Reference Data Maintenance function must interface with:

1. Drug updating service,
2. CMS-HCPCS updates,
3. ICD-9 or other diagnosis/surgery code updating service,
4. DRG Updates,
5. POS Contractor, and
6. Data Warehouse and Web Portal.

C.6.4 PRIOR AUTHORIZATION (PA) PROCESSING

The Prior Authorization Processing function is a mechanism to review, assess, and pre-approve selected non-emergency medical services prior to actual delivery. It serves as a cost-containment and utilization review mechanism for the District of Columbia medical assistance program, and enables the MMIS to approve payment for only those treatments and/or services that are medically necessary, appropriate, or cost-effective. Additional objectives of the District which are implemented through the Prior Authorization Processing function are to:

1. Enable the District to periodically revise the types of services for which prior authorization is required;
2. Control the amount that the Medicaid Program pays for specified services; the amount approved through the prior authorization process may never exceed the amount indicated on the procedure file, but it may be less than the procedure file price;

3. Provide the capability to change at any time the scope of services authorized and to extend or limit the effective dates of authorization; and
4. Identify the status of prior authorizations, to include pended, approved, and denied.

C.6.4.1 Inputs

The inputs to the Prior Authorization Processing function are:

1. On-line entry of prior authorization approval, renewal, or change information by District staff and contract staff (Example Delmarva) to prior authorization files which support both medical, dental, and special program prior authorization functions;
2. Interface with DC Medicaid enterprise Web Portal;
3. Interface with prior authorization contract staff via broadband or ISDN or T1 or telephone modem to allow access MMIS prior authorization screens to approve, deny, and suspend claims into the MMIS system directly.
4. Reported changes in recipient status; for example, death, change in level of care, level of severity and eligibility for programs;
5. Batch or real time update via X12N 278 transactions used PC modem or from Web Portal; and
6. Updates from claims processing that "draw down" authorized services, units, dollars, and/or percentages and from adjustment processing to "add back" services, units, dollars and /or percentages.

C.6.4.2 Processing Requirements

The Prior authorization function included in the proposed system shall:

C.6.4.2.1 Support the District's medical Prior Authorization function by maintaining a prior authorization data set with multiple line-items for requested and authorized services by procedure codes(s), range of procedure codes, unit of services billed and authorized with the following minimum information:

1. A unique, system assigned PA number;
2. ID of authorized provider;
3. Recipient ID, recipient name, and age for whom services are requested;
4. Method of transmittal;
5. multiple line items for requested and approved authorized services by revenue code, procedure code(s), multiple modifiers or all modifiers, range of procedure codes, tooth numbers, quadrants,

units billed and authorized; dollar amount billed and authorized; percentage of billed and authorized;

6. Units of service exhausted/remaining, including those recouped in claim adjustments;
7. Diagnosis, place of service, date of service, and category of service and description;
8. Approval, pended or denial reason codes;
9. Prior authorization request date of receipt, date of entry, and date of decision;
10. Beginning and ending dates during which the PA is valid;
11. Cross-reference to claims paid under the PA;
12. ID of authorizing person; and
13. Date of PA request.

C.6.4.2.2 Maintain a free-form text area on the PA record for special considerations, along with a flag to allow the system to identify authorizations with special considerations.

C.6.4.2.3 Accept on-line, real-time entry and update of Prior Authorization requests.

C.6.4.2.4 Maintain password control of inquiry, entry, updates, or change to the PA data set.

C.6.4.2.5 Assign system-generated unique PA numbers to PA requests.

C.6.4.2.6 Edit to prevent duplicate PA numbers from being entered into the system.

C.6.4.2.7 Edit PAs on-line to include:

1. Valid provider ID and eligibility;
2. Valid recipient ID and eligibility;
3. Valid procedure, diagnosis code;
4. Presence of required claim-type-specific data on the PA; and
5. Duplicate authorization check for previously authorized or previously adjudicated services.

C.6.4.2.8 Identify PAs containing errors with a status of suspended.

C.6.4.2.9 Identify errors on suspended prior authorizations as to the specific field in error and the particular edit that was failed.

C.6.4.2.10 Accept on-line, real-time corrections to suspended PAs.

C.6.4.2.11 Maintain and update PA units and/or dollars used based on claims processing to indicate that the authorized service has been used or partially used up, and to restore units and/or dollars when a claim is adjusted.

C.6.4.2.12 Purge old PA records at District direction.

C.6.4.2.14 Provide on line updateable letter templates for all prior authorization letters with the ability to add free form text specific to add free form text specific to a provider or recipient.

C.6.4.2.15 Automatically generate letters to recipients, agencies and/or providers for prior authorization denied and reasons why or requesting additional information or approval. X12N 278 response, if provider enrolled to use of standard transaction.

C.6.4.2.16 Provide the capability to perform mass updates of prior authorization records; for example, when there is a change made and a procedure mo longer requires prior authorization.

C.6.4.2.17 Provide the ability to submit prior authorization requests, receive confirmations and other related information in a secured, password protected web site. The web-enabled Prior Authorization system shall accept and send HIPAA compliant EDI formats and meet MAA security, confidentiality and privacy requirements and HIPAA and other federal security, confidentiality and privacy requirements.

C.6.4.2.18 Maintain an on-line audit trial of all updates to prior authorization data.

C.6.4.3 Information Retrieval

At a minimum, the proposed system must be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information must be made available in report format, on-line, or through another medium as specified by the District. To support the Prior Authorization function the system must:

C.6.4.3.1 Provide on-line terminal inquiry access to the Prior Authorization data set, even after the PA is closed or all services have been used.

C.6.4.3.2 Maintain on-line inquiry to all information in the PA data set with access by recipient ID, provider ID, and PA number with a secondary access keyed by service code and service date range for recipient and provider inquiries.

C.6.4.3.3 Generate approval, denial, and pending notices to providers, recipients, districts, and departments.

C.6.4.3.4 Generate reports that, at a minimum, include:

1. Type of authorization and number approved/denied by authorizer, units and dollar value of services used and not used;
2. Duplicate or overlapping PAs;
3. Frequency of service codes requested and authorized;
4. Cost savings (amount requested versus amount approved);
5. Utilization reports (including the number of times particular services were approved);
6. Prior authorization by entering clerk ID, sorted by authorization type, including the status and date of entry, date of referral, and date of decision for each prior authorization;
7. Reports to meet all federal and district reporting requirements;
8. Monthly reports of denials (including denial reason), approvals, pends, (including pending reason), with YTD totals; and
9. PAs not used within six (6) months of approval.

C.6.4.4 Interfaces

The Prior Authorization (PA) processing function shall accommodate interface needs with the following:

1. Data Warehouse and Web Portal.
2. Safe Passages Integration System (SPIS)

C.6.5 CLAIMS CONTROL

The Claims Control function ensures that all claims and related input to the MMIS are captured at the earliest possible time and in an accurate manner. This function monitors the movement and distribution of claim batches once they are entered into the system to ensure an accurate trail from receipt of claims through data entry, to final disposition. The function includes both manual and automated processes for claim control.

Additional objectives of this function of the MMIS are to:

1. Maintain control over all transactions during their entire processing cycle,

2. Provide accurate and complete registers and audit trails of all processing, and
3. Monitor the location of all claims at all times.

C.6.5.1 Inputs

The inputs to the Claims Control function are described in Subsection C.6.6, Claims Entry function.

C.6.5.2 Processing Requirements

The processing capabilities that shall be present in the MMIS to support the Claims Control function are:

C.6.5.2.1 Identify, upon receipt, each claim, adjustment, and financial transaction with a unique control number that includes date of receipt, batch number, claim input media, and sequence of document within the batch.

C.6.5.2.2 Monitor and track all claims, adjustments, and financial transactions from receipt to final disposition.

C.6.5.2.3 Maintain a microform image of all claims, attachments, adjustment requests, and other documents. The microform must contain an image of the claim, regardless of how it was submitted, and a complete index to all claims contained on the microform.

C.6.5.2.4 Maintain batch controls and batch audit trails for all claims and other transactions entered into the system.

C.6.5.2.5 Identify any activated claim batches that fail to balance to control counts.

C.6.5.2.6 Edit to prevent duplicate entry of electronic media claims.

C.6.5.2.7 Provide processes and data to meet minimum requirements in Part 11 of the State Medicaid Manual.

C.6.5.3 Information Retrieval

At a minimum, the proposed system shall be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information must be made available in report format, on-line, or through another medium as specified by the District. To support the Claims Control function the system shall provide for:

C.6.5.3.1 On-line inquiry to claims, adjustments, and financial transactions, from data entry to adjudication, with access keys specified in paragraph C.6.10.2.8.

C.6.5.3.2 Easy retrieval of microform images by control number.

C.6.5.3.3 An audit trail record with each claim record that shows any error codes posted to the claim in current processing.

C.6.5.3.4 Inventory management analysis by claim type, processing location, and age.

C.6.5.3.5 Input control listings.

C.6.5.3.6 Returned claim logs.

C.6.5.3.7 Exception reports of claims in suspense in a particular processing location for more than a user-specified number of days.

C.6.5.3.8 Inquiry screens to include pertinent header and detail claim data and status.

C.6.5.4 Interfaces

There are no external automated interfaces identified for the Claims Control function.

C.6.6 CLAIMS ENTRY

After claims and other transactions have been prepared for processing during claims receipt and control, they are entered into the MMIS for pricing and edit/audit processing. The Claims Entry function ensures the accuracy, reasonableness, and integrity of MMIS entered data for further processing.

The Claims Entry function of the MMIS shall accept claims and other transactions via hard-copy and electronic media to include tape, diskette and electronic transmission. It is the intent of the District of Columbia to maximize the use of electronic claims entry.

C.6.6.1 Inputs

Inputs to the Claims Entry function are the inputs for all of the claims processing functions. They consist of:

1. Claim forms (in both hard-copy and electronic formats) including:
   a) CMS-1500 (12-90 version);
   b) UB-92 (when implemented in October 1993);
   c) ALL X12N transactions, that includes 837 I, P, Ds where electronic media may include magnetic tape, diskette, CD, DVD or direct entry via personal computer using dial-up telecommunications facilities or public telecommunications networks;

2. Any other standard forms required by special programs or service categories;
3. Crossover claims for Medicare coinsurance and deductible, for Part A and Part B;
4. Claim adjustment documents, including crossover adjustments;
5. Attachments required for claims adjudication, including:
   a) TPL Explanation of Benefits;
   b) sterilization, abortion, and hysterectomy consent forms; and
   c) medical documentation to support medical review;
6. Manual or automated medical expenditure transactions which have been processed outside of the MMIS; and
7. Non-claim specific financial transactions such as fraud and abuse settlements, TPL recoveries, and cash receipts.

C.6.6.2 Processing Requirements

The Claims Entry function will rely on manual and automated procedures to ensure the accuracy and reasonableness of the entered claims data. The capabilities that the MMIS shall have to support the claims entry function are:

C.6.6.2.1 Accept claims via hard-copy or electronic media formats from providers, billing services, and Medicare carriers and intermediaries.

C.6.6.2.2 Identify claims for services covered under each of the various MAA programs.

C.6.6.2.3 Provide the capacity for key re-verification of critical fields, data entry software editing, supervisor audit verification of keyed claims, or other methods determined acceptable by the District.

C.6.6.2.4 Maintain extract files which contain key elements of support files to verify the validity of entered claim information and the accuracy of keying; extract files will be updated with current information during the same cycle for which update transactions are applied to file records.

C.6.6.2.5 Identify, and allow on-line correction to, claims with data entry errors.

C.6.6.2.6 Provide processes and data to meet minimum requirements of Part 11 of the State Medicaid Manual.

C.6.6.3 Information Retrieval

The primary output of the Claims Entry function is the transmission of MMIS entered claim, adjustment and financial transaction data into the Claims Edit/Audit, Pricing, and Financial Processing functions for processing. In addition, these types of reports shall be produced as outputs of the Claims Entry function:

1. Claims entry statistics;
2. Data entry operator statistics, including volume, speed, and accuracy; and

3. Electronic submission statistics.

C.6.6.4 Interfaces

The Claims Entry function must interface with provider, biller, and Medicare carrier and intermediary electronic networks as applicable. These include:

1. Telecommunication links, and
2. Personal computer.

C.6.7 EDIT/AUDIT PROCESSING

The Edit/Audit Processing function ensures that claims are processed in accordance with District of Columbia policy. This processing includes application of non-history-related edits and history-related audits to the claim. Claims are screened against recipient and provider eligibility files; pended and paid/denied claims history; and procedure, drug, diagnosis, and edit/audit files. Those claims that exceed Program limitations or do not satisfy Program or processing requirements, suspend with error messages. They are then reviewed by Contractor staff using District-approved adjudication guidelines, or forwarded to the District for medical review or manual pricing.

C.6.7.1 Inputs

The inputs to the Edit/Audit Processing function are the claims that have been entered into the claims processing system from the Claims Entry function, claims that are recycled after correction, and claims released to editing after a certain number of cycles based on defined edit criteria.

C.6.7.2 Processing Requirements

Complete identification of edit criteria will occur during the requirements analysis phase of the implementation contract. Basic editing necessary to pass the claims onto subsequent processing requires that the MMIS has the capabilities to:

C.6.7.2.1 Reformat key-entered and EMC claims into common processing formats for each claim type.

C.6.7.2.2 Edit each data element on the claim record for required presence, format, consistency, reasonableness, and/or allowable values.

C.6.7.2.3 Identify all error codes for claims which fail daily processing edits at initial processing, so as to not require multiple resubmissions of claims.

C.6.7.2.4 Identify the processing outcome of claims (suspend or deny) which fail edits, based on the edit disposition file.

C.6.7.2.5 Provide for on-line resolution of suspended claims.

C.6.7.2.6 Identify potential third-party liability (including Medicare) and deny the claim if it is for a service covered or presumed to be covered by a third-party, based on procedure codes, drug codes, categories of service, the TPL carrier coverage matrix, or a combination of data from these sources.

C.6.7.2.7 Edit to assure that TPL has been satisfied and that a TPL denial attachment is present if required; suspend claims for prepayment review for potential TPL based on amount billed, claim type, procedure code, diagnosis code, insurance indicators, and other District-specified criteria.

C.6.7.2.8 Edit to assure that the services for which payment is requested are covered by the District of Columbia Medical Assistance Program.

C.6.7.2.9 Edit to assure that all required attachments, per the reference files, are present.

C.6.7.2.10 Edit for and suspend claims requiring provider or recipient prepayment review.

C.6.7.2.11 Maintain a function to process claims against an edit/audit criteria table and an error disposition file (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.

C.6.7.2.12 Edit to assure that reported diagnosis and procedure codes are present on Medicare crossover claims and all other appropriate claim types.

C.6.7.2.13 Edit for recipient eligibility on date(s) of service.

C.6.7.2.14 Apply edits to identify claims for newborns for whom eligibility records have not yet been created, but for whom claims may be paid based on the mother's eligibility.

C.6.7.2.15 Edit for special eligibility records indicating recipient participation in special programs where program service limitations or restrictions may vary.

C.6.7.2.16 Edit provider eligibility to perform type of service rendered on date of service.

C.6.7.2.17 Edit for provider participation as a member of the billing group.

C.6.7.2.18 Edit nursing home claims against recipient stay data, patient liability, and admit/discharge information.

C.6.7.2.19 Edit for prior authorization requirements and to assure that a prior authorization number is present on the claim and matches to an active prior authorization on the MMIS.

C.6.7.2.20 Edit prior-authorized claims and cut back billed units or dollars, as appropriate, to remaining allowed units or dollars.

C.6.7.2.21 Edit for prior authorization on orthodontia claims where such authorization may cause the claim to be payable even when recipient eligibility has ended.

C.6.7.2.22 Maintain edit disposition to deny claims for services that require prior authorization if no PA is identified or active.

C.6.7.2.23 Update the prior authorization record to reflect the services paid on the claim and the number of services still remaining to be used.

C.6.7.2.24 Perform automated cross-checks and relationship edits on all claims.

C.6.7.2.25 Perform automated audit processing using history claims, suspended claims, and same cycle claims.

C.6.7.2.26 Edit for potential duplicate claims based on a cross-reference of group and rendering provider, multiple provider locations, and across provider and claim types.

C.6.7.2.27 Identify exact duplicate claims in the system.

C.6.7.2.28 Perform automated edits using duplicate audit and suspect-duplicate criteria to validate against history and same cycle claims.

C.6.7.2.29 Refine duplicate checking criteria to achieve a cost effective balance between duplicate suspense rates and duplicate payments.

C.6.7.2.30 Maintain up to 20 current and 20 previous error code occurrences per claim header and claim detail.

C.6.7.2.31 Edit and suspend each line on a multi-line non-institutional claim independently.

C.6.7.2.32 Edit each claim record completely during an edit or audit cycle, rather than ceasing the edit process when an edit failure is encountered**.**

C.6.7.2.33 Identify and track all edits and audits posted to the claim in a single cycle.

C.6.7.2.34 Provide, for each error code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied; forced claims shall carry the ID of the operator.

C.6.7.2.35 Accept overrides of claim edits and audits in accordance with District guidelines.

C.6.7.2.36 Identify the claim disposition based on the edit status or force code with the highest severity; the severity shall be readily modifiable on the Reference files.

C.6.7.2.37 Integrate multiple edit processing runs into a single audit processing run, when required.

C.6.7.2.38 Update claim history files with paid and denied claims from the previous audit run.

C.6.7.2.39 Maintain a record of services needed for audit processing where the audit criteria covers a period longer than 27 months (such as once-in-a-lifetime procedures).

C.6.7.2.40 Provide the capability to easily change the disposition of edits to (1) pend to a specific location, (2) deny, (3) pay and report, or (4) pay.

C.6.7.2.41 Maintain flexibility in setting claim edits to allow dispositions and exceptions to edits based on bill/claim type, or submission media.

C.6.7.2.42 Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.6.7.2.43 Edit for time limits on dollars or units, as needed.

C.6.7.2.44 Edit claims with billed amounts that vary by a specified degree above or below allowable amounts.

C.6.7.2.45 Edit billing, performing, referring, attending, operating and prescribing provider IDs for validity.

C.6.7.3 Information Retrieval

The outputs of the Edit/Audit Processing function are the updated claim records used in subsequent processing. Reports generated as a result of edit/audit cycle processing are included in C.6.10.3. The proposed system shall provide for on-line inquiry into edit/audit status of claims in process.

C.6.7.4 Interfaces

There are no external automated interfaces for the Edit/Audit function.

C.6.8 CLAIMS PRICING

The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each claim type, category of service, and type of provider. This process takes into consideration the Medicaid allowed amount, TPL payments, Medicare payments, patient payments and prior authorized amounts. Prices are maintained on the Reference files or provider-specific rate files and are date-specific.

The MMIS shall process and pay Medicare crossover claims.

C.6.8.1 Inputs

The inputs into the Claims Pricing function are the claims that have been passed from the editing cycles for pricing.

The Reference, Provider, and PA files containing pricing information are also inputs to this function.

C.6.8.2 Processing Requirements

The Claims Pricing function of the MMIS shall have the capabilities to:

C.6.8.2.1 Identify the price for claims according to the date-specific pricing data and reimbursement methodologies contained on Provider or Reference files based on date of service on the claim.

C.6.8.2.2 Edit billed charges for high and low variances and flag any exceptions.

C.6.8.2.3 Identify and calculate payment amounts according to the fee schedules, per diem, rates, and rules established by the District including the possible expanded use of fee schedules for outpatient services besides outpatient laboratory services.

C.6.8.2.4 Maintain access to pricing and reimbursement methodologies to appropriately price claims based on:

1. Fee schedules for physicians, dentists, and other practitioners;
2. DRGs, per diem, and percent of charges for inpatient hospital services;
3. Fee schedules for laboratory outpatient services and other pricing methods for outpatient services;
4. Per diem for nursing homes;
5. Medicare deductible and coinsurance amount for crossover claims; and
6. Per capita monthly amount for HMOs.

C.6.8.2.5 Deduct patient liability amounts when pricing long-term care claims.

C.6.8.2.6 Deduct TPL amounts, as appropriate, when pricing claims.

C.6.8.2.7 Provide for the ability to price Medicare coinsurance or deductible crossover claims either at the Medicaid allowed amount or as the amount of coinsurance and deductible. In pricing by Medicaid allowed amount, Part B Medicare pricing should be done at the line item level.

C.6.8.2.7.1 Ensure that the Medicare crossover claims for which, payments is requested, are covered by the District of Columbia Medical assistance program and that the Medicare portion of the claim had already been **paid.**

C.6.8.2.8 Maintain flexibility to accommodate pricing of alternative service delivery systems, such as case-management, managed care, and HMOs without major system modifications, including alternative pricing for case managers or gatekeepers.

C.6.8.2.9 Price procedure codes allowing for multiple modifiers, which enable reimbursement at varying percentages of allowable amounts.

C.6.8.2.10 Maintain multiple prices (at least 36 prices) for each LTC provider reimbursement methodology.

C.6.8.2.11 Provide processes and dates to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.6.8.3 Information Retrieval

The outputs of the Claims Pricing function are priced claims that are passed on for financial processing or suspended claims due to pricing edits.

C.6.8.4 Interfaces

There are no external automated interfaces identified for the Claims Pricing function.

C.6.9 CLAIMS CORRECTION

The Claims Correction function supports the correction of claims that have suspended during edit, audit, or pricing processing. The objective of this function is to support as much on-line claims resolution as possible.

C.6.9.1 Inputs

The inputs to the Claims Correction function are:

1. On-line entry of claim corrections to the fields in error;
2. On-line forcing or overriding of certain edits; and
3. Provider, recipient, PA, and reference data related to the suspended claims.

C.6.9.2 Processing Requirements

In order to meet the processing objectives of the Claims Correction function, the MMIS shall have the following capabilities:

C.6.9.2.1 Provide on-line, real-time claims resolution and edit override capabilities for all claim types.

C.6.9.2.2 Maintain claim correction screens which display all claims data as entered or subsequently corrected.

C.6.9.2.3 Completely re-edit corrected claims.

C.6.9.2.4 Maintain inquiry and update capability to claim correction screens with access keys as specified in C.6.10.2.8.

C.6.9.2.5 Accept global releases to suspended claims based on District-defined criteria, and release claims to editing.

C.6.9.2.6 Maintain error codes and messages that clearly identify the reason(s) for the suspension and highlight the fields in error on claim correction screens; display all failed edits on screens to facilitate claim correction.

C.6.9.2.7 Provide access to related provider data from the Provider Data Maintenance function through windowing, split screen, or other electronic techniques.

C.6.9.2.8 Provide access to related recipient data from the Recipient Data Maintenance function through windowing, split screen, or other electronic techniques.

C.6.9.2.9 Provide access to related reference data from the Reference Data Maintenance function through windowing, split screen, or other electronic technique.

C.6.9.2.10 Identify and provide access to potential duplicate claims and related claims data from the claims history and status files through windowing, split screen, or other electronic technique.

C.6.9.2.11 Assign a claim status of "pended" to all claims to be corrected.

C.6.9.2.12 Assign a unique status to corrected claims.

C.6.9.2.13 Maintain all claims on the suspense file until corrected, automatically recycled, or automatically denied according to District specifications.

C.6.9.2.14 Provide the capability to identify operators who can perform a force or override on an error code based on individual operator IDs or authorization level.

C.6.9.2.15 Provide processes and data to meet minimum requirements of Part 11 of the State Medicaid Manual.

C.6.9.3 Information Retrieval

The Claims Correction function generates updated claim records to recycle through edit and audit processing. The proposed system shall be capable of retrieving information on-line to support the claims correction process, as defined above, and to document claim corrections once they have been accomplished.

C.6.9.4 Interfaces

There are no external automated interfaces identified for this function.

C.6.10 CLAIMS OPERATIONS MANAGEMENT

The Claims Operations Management function provides the overall support and reporting for all of the claims processing functions. It specifies the on-line claims status and history, processing cycles, and inventory and other general reporting requirements for the claims processing functions.

C.6.10.1 Inputs

The inputs to the Claims Operations Management function shall include all the claim records from each processing cycle and other inputs described in Subsection C.6.6.1.

C.6.10.2 Processing Requirements

The primary processes of Claims Operations Management are to maintain sufficient on-line claims information, provide on-line access to this information, and produce claims processing reports. The capabilities that shall be included in this function are to:

C.6.10.2.1 Maintain twenty-seven (27) months of adjudicated (paid and denied) claims history on a current, active claims history file for use in audit processing, on-line inquiry and update, and printed claims inquiries, including, at a minimum:

1. Diagnosis code at the header and detail level;
2. Line item procedure codes, including modifiers;
3. Billing and rendering provider;
4. Up to 20 current error codes at the detail level and 20 previous error codes;
5. Billed, allowed, and paid amounts;
6. TPL amounts, if any;
7. Procedure, drug, or other service codes; and
8. Date of service, date of adjudication, date of payment.

C.6.10.2.2 Provide on-line inquiry to suspended claims and their current status, showing claim detail and the edits/audits applied to the claim, with access keys as specified in C.6.10.2.8.

C.6.10.2.3 Maintain claims that have been archived from active claims history indefinitely on a permanent history with key elements of the history claim.

C.6.10.2.4 Maintain a record of any services that, due to District policy, are required for processing for a longer span of time than that covered by the active claims history (such as once-in-a-lifetime procedures) on active claims history for audit processing.

C.6.10.2.5 Maintain batch claim detail reporting capabilities by provider ID or recipient ID, with multiple select and sort options, against current history.

C.6.10.2.6 Allow on-line request of claim detail reports and show all claims, adjustments, and financial transactions that have occurred within the period for the selection parameters requested.

C.6.10.2.7 Maintain non-claim-specific financial transactions on claims history.

C.6.10.2.8 Provide on-line inquiry access to the claims files based on multiple selection criteria, including, but not limited to:

1. Recipient number,
2. Provider number, and
3. Claim control number.

Further limit the on-line inquiry by:

1. Dates of service,
2. Dates of payment,
3. Claim status,
4. Place of service
5. Claim type,
6. Category of service,
7. Provider type, and
8. Remittance number.

C.6.10.2.9 Provide summary screens with the number and dollar amounts of claims meeting the selection criteria.

C.6.10.2.10 Perform, at a minimum, one (1) edit and pricing processing cycle, one (1) audit processing cycle, and one (1) payment processing cycle weekly.

C.6.10.2.11 Maintain a process to generate recipient Explanation of Medical Benefits (EOMBs) to a District-approved sample and selection of recipients receiving services during the reporting period, with special consideration for confidential services.

C.6.10.2.12 Track and update the claims inventory (to be processed, suspend, paid and denied) after each claims processing cycle.

C.6.10.2.13 Maintain the identity of the entity responsible for the claim based on provider type, provider ID, place of service and/or type of service; for example, SCHIP, Medicaid or other.

C.6.10.2.14 Maintain the identity of the funding source and federal funding level for each claim.

C.6.10.2.15 Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.6.10.2.16 Provide a weekly status report of Contractor activities, to include claims receipt and processing inventory, provider relations' activity, system change request activity, and so forth.

C.6.10.3 Information Retrieval

Besides the inquiry screens identified, the Claims Operations Management function must include, at a minimum, the following types of outputs and reports. They will be produced on paper, fiche, and on-line media:

C.6.10.3.1 Inventory management analysis by claim type, processing location, and age.

C.6.10.3.2 Report of receipts and production, by type of media, of claims received and processed to a finalized status.

C.6.10.3.3 Report of claims inventory, processing activity, and average age of claims.

C.6.10.3.4 Inventory trend reports.

C.6.10.3.5 Report of claims and payments after each payment cycle, by claim type and MARS category of service.

C.6.10.3.6 Report of finalized claims, tapes, and EMC transmissions input into the weekly payment cycle.

C.6.10.3.7 Error code analysis by claim type, provider and/or input media.

C.6.10.3.8 Edit/audit override analysis by claim type, edit/audit and operator ID.

C.6.10.3.9 Payment cycle time analysis by claim type, input media, and provider type.

C.6.10.3.10 Prepayment edit/audit savings by claim type, edit/audit and operator ID.

C.6.10.3.11 Reports on "specially handled" or manually processed claims.

C.6.10.3.12 User-requested ad-hoc reports from paid claims information.

C.6.10.3.13 Recipient EOMBs, which include all services provided to a recipient by any participating provider, except for confidential services, and a layperson's description of the services provided, the date(s) of service, and the payment amount.

C.6.10.3.14 Summary reports of the EOMBs generated.

C.6.10.3.15 Recipient and provider history printouts of adjudicated and/or suspended claims that include a description of procedure, drug, diagnosis, and error codes.

C.6.10.3.16 Pay cycle, adjudicated claims files available for downloading to District Data Warehouse and Web Portal, including paid and denied claims, adjustments, capitation, and other payments and financial transactions. Claim information, which must be documented, could potentially include all data elements captured and processed by the MMIS.

C.6.10.4 Interfaces

The Claims Operations Management function shall establish and maintain an interface with the District Data Warehouse and Web Portal for monthly adjudicated claims data extracts.

C.6.11 FINANCIAL PROCESSING

The Financial Processing function encompasses claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing. It ensures that all District funds are appropriately disbursed for claim payments and all post-payment transactions are applied accurately.

The Financial Processing function is the last step in claims processing. It produces the remittance advice, the financial reports and a request to the District Treasurer for check issuance. At the end of each weekly claims processing cycle, the Financial Processing function processes each provider's finalized claims and outstanding accounts due to the District.

C.6.11.1 Inputs

The Financial Processing function shall accept the following inputs:

1. Adjudicated claims and claim adjustments from the claims processing system;
2. Adjudicated claims to be paid from the POS Contractor;
3. On-line entered, non-claim-specific financial transactions, such as recoupments, mass adjustments, cash transactions, and so forth; and
4. Provider, recipient, PA, and reference data from the MMIS.

C.6.11.2 Processing Requirements

The District of Columbia MMIS shall perform financial processing in three basic functional areas: 1) payment processing; 2) adjustment processing; 3) other financial processing. Required system capabilities are classified under one of these headings in these subsections.

C.6.11.2.1 Payment Processing - Claims that have passed all edit, audit, and pricing processing, or which have been denied, are passed on for payment processing. Payment processing must include the capability to:

C.6.11.2.1.1 Maintain payment mechanisms to providers.

C.6.11.2.1.2 Maintain provider accounts receivables and deduct appropriate amounts from processed payments.

C.6.11.2.1.3 Generate provider remittance advice (RA) in electronic HIPAA standard format or hard-copy media, to include the following information:

1. An itemization of submitted claims that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals;
2. An itemization of suspended claims, including date of receipt and suspense, and dollar amount billed;
3. Adjusted claim information showing both the original claim information and the adjusted information, with an explanation of the adjustment reason code;
4. Reason for procurement;
5. Indication that a claim has been rejected due to TPL coverage on file for the recipient with a special message giving the recipient's policy and group number as well as the insurance carrier and address;
6. Explanatory messages relating to the claim payment cutback or denial;

7. Summary section containing earnings information regarding the number of claims paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period, month-to-date and year-to-date; and
8. A list of all relevant error messages per claim header and claim detail, which would cause a claim to be denied.

C.6.11.2.1.4 Provide flexibility in the format, sequences and content of the remittance advice for different claim types (such as hospital, pharmacy, professional, LTC).

C.6.11.2.1.5 Provide the capability to print informational messages on RAs, with multiple messages available on a user-maintainable message text file, with parameters such as provider type, claim type, and payment cycle date(s).

C.6.11.2.1.6 Provide the flexibility to suppress the generation of zero-pay warrants but do generate associated remittance advice.

C.6.11.2.1.7 Maintain a process to automatically establish an account receivable for a provider if the net transaction of claims and financial transactions results in a negative amount.

C.6.11.2.1.8 Update provider payment data and 1099 data on the Provider data set.

C.6.11.2.1.9 Create a warrant file to be used by the District to reimburse its medical providers.

C.6.11.2.2 Adjustment Processing - Adjustments will be processed in the regular claims processing cycles. The MMIS adjustment processing function must have the capabilities to:

C.6.11.2.2.1 Maintain complete audit trails of adjustment processing activities on the claims history files.

C.6.11.2.2.2 Update provider and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including TPL claim-specific recoveries.

C.6.11.2.2.3 Maintain a process to identify the claim to be adjusted, display it on a screen, and change the fields to be adjusted with minimal entry of new data.

C.6.11.2.2.3 Maintain the original claim and the results of adjustment transactions in claims history; link all claims and subsequent adjustments by control number.

C.6.11.2.2.4 Reverse the amounts previously paid and then process the adjustment so that the adjustment can be easily identified.

C.6.11.2.2.5 Provide the methodology to process the adjustment offset in the same payment cycle as the adjusting claim.

C.6.11.2.2.6 Re-edit, re-price, and re-audit each adjustment, including checking for duplication against other regular and adjustment claims, in history and in process.

C.6.11.2.2.7 Maintain an adjustment reason code that indicates the reason for the adjustment and the disposition of the claim (additional payment, recovery, history only, and so forth) for use in reporting the adjustment.

C.6.11.2.2.8 Provide the methodology to allow on-line changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process.

C.6.11.2.2.9 Maintain a mass-adjustment function to re-price claims for retroactive pricing changes, recipient or provider eligibility changes, and other changes necessitating reprocessing of multiple claims.

C.6.11.2.2.10 Maintain an on-line mass-adjustment selection screen, limited to select users, to enter selection parameters such as time period, provider number(s), recipient number(s), service code(s), and claim type(s); claims meeting the selection criteria will be displayed for initiator review, and the initiator will have the capability to select or unselect chosen claims for continued adjustment processing.

C.6.11.2.2.11 Maintain a retroactive rate adjustment capability which will automatically identify all claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim.

C.6.11.2.2.12 Maintain control to apply successive adjustments to the most current version of the claim.

C.6.11.2.2.13 Update prior authorization units and dollars used for each claim adjustment or void that is adjudicated to be paid.

C.6.11.2.2.14 Provide an automated process, which will close HMO spans on the recipient eligibility file and adjust capitation payments when an HMO closes.

C.6.11.2.3 **Other Financial Processing** - Financial transactions such as voids, reissues, manual checks, cash receipts, repayments, cost settlements, overpayment adjustments, and recoupments will be processed as part of the Financial Processing function. To process them, the MMIS must have the capabilities to:

C.6.11.2.3.1 Maintain on-line access and update capability to an accounts receivable file which processes and reports financial transactions by type of transaction and provider or other entity (for example, carrier, drug manufacturer). The file, at a minimum, must include:

1. Provider number/entity identification,
2. Account balance,

3. Percent or dollar amount to be withheld from future payments,
4. Reason indicator,
5. Type of collection,
6. Authorizing party,
7. Due date for recoupment,
8. Program and authorizing agency to be charged,
9. Lien holder and amount of lien, and
10. 1099 adjustment indicator.

C.6.11.2.3.2 Maintain sufficient controls to track each financial transaction, balance each batch, and maintain appropriate audit trails on the claims history file.

C.6.11.2.3.3 Maintain on-line inquiry to financial information with access by provider ID or entity identification; at a minimum include:

1. Overpayment information,
2. Receivable account balance and established date,
3. Percentages and/or dollar amounts to be deducted from payments,
4. Type of collections made and date,
5. Both financial transactions (non-claim-specific) and adjustments (claim-specific), and
6. Data to meet CMS-64 reporting.

C.6.11.2.3.4 Maintain a recoupment process, which sets up provider accounts receivable that can be either automatically recouped from claims payments or satisfied by repayments from the provider or both.

C.6.11.2.3.5 Maintain the capability to identify and recoup from all providers who have received payment for services to a recipient following the date of death.

C.6.11.2.3.6 Maintain a methodology to apply monies received toward the established recoupment to the accounts receivable file, including the remittance advice date, number, and amount, and transfer that data to an on-line provider paid claims summary.

C.6.11.2.3.7 Identify a type and disposition on refunds or pay outs.

C.6.11.2.3.8 Provide a method to link refunds to the specific claim affected, according to cost-effective guidelines established by the District.

C.6.11.2.3.9 Generate provider 1099 reports annually, which indicate the total paid claims minus any recoupments or credits.

C.6.11.2.3.10 Maintain a process to adjust providers' 1099 earnings reports with pay-out or recoupment amounts issued in the accounts receivable file.

C.6.11.2.3.11 Maintain a process to accommodate the issuance and tracking of non-provider-specific payments through the MMIS (for example, refund of an insurance company overpayment) and adjust expenditure reporting appropriately.

C.6.11.2.3.12 Maintain lien and assignment information to be used in directing or splitting payments to the provider and lien holder.

C.6.11.2.3.13 Identify providers with credit balances and no claim activity during a District-specified number of months.

C.6.11.2.3.14 Generate overpayment letters to providers when establishing accounts receivables.

C.6.11.2.3.15 Identify and track shared expenditures with other agencies.

C.6.11.2.3.16 Track all financial transactions, by source, to include TPL recoveries, fraud and abuse recoveries, provider payments, drug rebates, and so forth.

C.6.11.2.3.17 Accept claim-specific and gross recoveries, regardless of submitter (provider, carrier, recipient, drug manufacturer); apply gross recoveries to providers or recipients as identifiable.

C.6.11.2.3.18 Maintain a process of fiscal pends, wherein payments are held on adjudicated claims based on criteria established by the District, to include claim type, provider type, specific ID, and dollars; the District will specify release of fiscal pends based on the above, or other established criteria.

C.6.11.2.3.19 Provide processes and data to meet minimum requirements in Part 11 of the State Medicaid Manual.

C.6.11.2.3.20 Provide a process to designate to which Federal fiscal year recoveries are to be shown.

C.6.11.2.3.21 Maintain a process to provide data and generate the CMS-37, Medicaid Program Budget Report.

C.6.11.3 Information Retrieval

The outputs of the Financial Processing function shall meet all Federal and District reporting requirements, and shall provide the information necessary to assess compliance with Federal certification.

C.6.11.3.1 The reports shall be designed for ease of use and interpretations, reflect District needs, and include the following, at a minimum:

1. Reports of expenditures by department, program, and special Federal funding categories (Month-to-Date and Year-to-Date);

2. Counts of adjustments and other financial transactions, by provider type, claim type, and so forth;
3. Standard accounting balance and control reports;
4. Remittance summaries and payment summaries;
5. Gross receivables invoiced by accounting code;
6. Detailed financial transaction registers;
7. CMS-37;
8. CMS-64 worksheet by Federal financial participation rate;
9. CMS 37 2 waiver reports;
10. MSIS tapes;
11. 1099 tapes to IRS;
12. Quarterly recipient ranking by total claims by claim type or aid category;
13. Range of recoupments by amount and time period for providers;
14. Outstanding accounts receivable, with flags on those that have no activity within a District-specified period of time;
15. Cash receipts and returned funds;
16. Accounts receivable set-up during the reporting period;
17. Payment register;
18. Retroactive rate adjustments requested and performed; and
19. Reports that segregate and identify claim-specific and non-claim-specific adjustments by type of transaction (pay out, recoupment, or refund) and provider type on a monthly basis.

C.6.11.3.2 The Financial Processing function shall produce the remittance advice.

C.6.11.3.3 The Financial Processing function shall produce payment requests to District Treasurer for providers and other entities.

C.6.11.3.4 The Financial Processing function must produce manually issued check requests to District Treasurer.

C.6.11.4 Interfaces

The Financial Processing function shall accommodate interface needs with the following:

1. POS Contractor - Practitioner claims containing Diagnosis Codes.

C.6.12 THIRD PARTY LIABILITY (TPL) PROCESSING

The Third Party Liability (TPL) processing function helps the District of Columbia utilize the private health, Medicare, and other third-party resources of its Medical Assistance recipients, and ensures that Medical Assistance is the payer of last resort. This function works through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable also known as "pay and chase") and post-payment recovery (post-payment collection of amounts for which a third party is liable). Primary reliance is on cost avoidance, which is implemented automatically by the MMIS through use of edits and checks of various data fields on recipient and reference files. Post- payment recovery is utilized as a back-up to the cost avoidance process, and in certain situations where cost avoidance is impractical or unallowable.

The information maintained by the MMIS TPL processing function includes recipient TPL resource data, insurance carrier data, and post-payment recovery tracking data. TPL coverage type and threshold information are used by the Claims Processing function during claims adjudication.

The primary objectives of the District of Columbia MMIS TPL function are to:

1. Identify third-party resources available to Medical Assistance eligible,
2. Avoid paying for claims with potential third-party coverage,
3. Recover funds from third parties when TPL resources are identified after the fact,
4. Meet Federal and District TPL reporting requirements, and
5. Pay the premiums for private health insurance for recipients (including Medicare Buy-In) when it is cost-effective to do so.

C.6.12.1 Inputs

The following are inputs to the TPL function of the MMIS:

1. Data matches with files from other government programs and private insurance carriers;
2. Insurance carrier coverage data from a District maintained TPL matrix;
3. TPL-related data from claims, claim attachments, or claims history files, including:
   a) Diagnosis codes, procedure codes, or other indicators suggesting trauma or accident;
   b) Indication that a TPL payment has been made for the claim (including Medicare);
   c) Indication that the recipient has reported the existence of TPL to the provider submitting the claim; and

d) Indication that TPL is not available for the service claimed;

4. Recipient eligibility and TPL resource information from IMA based on initial recipient enrollment;
5. Common Work File (BENDEX);
6. TPL information developed by claims resolution workers following TPL edit errors;
7. Correspondence and phone calls from recipients, carriers, and providers;
8. Parameters entered on-line to identify paid claims for tracking and potential recovery; and
9. MMIS recipient, reference, and provider data.

C.6.12.2 Processing Requirements

The District of Columbia TPL processing function must include the following processing capabilities:

C.6.12.2.1 Maintain accurate third-party resource information by recipient including:

1. Name, ID number, date of birth, date of death, SSN of eligible recipient;
2. Policy number or Medicare HIC number and group number;
3. Name and address of policyholder, relationship to eligible recipient, SSN of policyholder;
4. Assignment/subrogation;
5. Cost-avoidance bypass indicator;
6. Employer name and address;
7. Premium amount;
8. Type of policy and coverage, effective date of coverage;
9. Date of TPL verification and ID of individual who completed the verification; and
10. Insurance carrier ID.

C.6.12.2.2 Maintain third-party carrier information that includes:

1. Carrier ID and name,
2. Correspondence address,
3. Contact person and phone number,
4. Claims submission address, and
5. Types of coverage.

C.6.12.2.3 Provide for fifteen (15) date-specific TPL resources (including Medicare) for each recipient.

C.6.12.2.4 Maintain historical information on third-party resources for each recipient.

C.6.12.2.5 Maintain a cross-reference of carrier and employer data.

C.6.12.2.6 Maintain the capability to display, inquire into, or update carrier coverage data on-line.

C.6.12.2.7 Maintain the capability to display, inquire into, or update recipient TPL data on-line.

C.6.12.2.8 Accept batch updates to the TPL resource data based on information from IMA.

C.6.12.2.9 Edit on-line transaction data for presence, format, validity, and consistency with other data in the update transaction and in the TPL files.

C.6.12.2.10 Edit all batch input transactions from interfacing systems and data match processes to ensure consistency and validity of data.

C.6.12.2.11 Identify recipients for whom insurance premiums are to be paid, including effective dates and amount of payment.

C.6.12.2.12 Identify all payments avoided due to established TPL, as defined by the District.

C.6.12.2.13 Maintain a process to identify previously paid claims for recovery when TPL resources are identified or verified retroactively, and to facilitate recovery within 60 days from the end of the month in which the claim was adjudicated.

C.6.12.2.14 Maintain a case-tracking system for post-payment recovery of paid claims due to health insurance, casualty, and District cases subject to a recovery action.

C.6.12.2.15 Assign each case on the recovery case-tracking system a case number for identification.

C.6.12.2.16 Provide for automated tracking of accounts receivable, by carrier.

C.6.12.2.17 Provide for automated tracking of recoveries, and posting of recoveries to individual claim histories.

C.6.12.2.18 Track individual claims and multiple claims that reach a set District-defined threshold (for example, $200) for post-payment recovery.

C.6.12.2.19 Accept free-form user notes on automated recovery case-tracking records.

C.6.12.2.20 Provide a process to perform data matching with other government agencies and private insurers for potential TPL resources.

C.6.12.2.21 Maintain the ability to relate members of a case so that policy information for all members can be entered with a single transaction.

C.6.12.2.22 Provide processes and data to meet minimum requirements in Part 11 of the State Medicaid Manual.

C.6.12.2.23 Maintain a process to pay deductible and coinsurance amounts for those individuals for whom insurance premiums are paid.

C.6.12.2.24 Maintain a process to meet the requirements of Section 3910 of the State Medicaid Manual regarding Medicaid Payments for Recipients Under Group Health Plans, including the cost-effective analysis.

C.6.12.2.25 Maintain the capability to download TPL data to DOH TPL unit workstations.

C.6.12.3 Information Retrieval

At a minimum, the proposed system shall be capable of retrieving data necessary to generate the following outputs and support the following information needs. The Contractor shall provide information in report format, on-line, or through another medium as specified by the District. To support the TPL processing function the system shall provide for:

C.6.12.3.1 Retrieval of paid claims from history based on user selected parameters including:

1. Pay date,
2. Date of service,
3. Claim type,
4. Provider type,
5. Category of service,
6. DRG code,
7. Diagnosis code or range,
8. Procedure code,
9. Remittance advice number,
10. Drug code,
11. Drug therapeutic class,
12. Provider number, and
13. Recipient ID.

C.6.12.3.2 Generation of cost-avoidance summary savings reports, including Medicare.

C.6.12.3.3 Detailed listing of cost-avoided claims.

C.6.12.3.4 Detailed listing of third-party resources utilized.

C.6.12.3.5 Listings of potential recovery claims based on user-input selection parameters.

C.6.12.3.6 Amounts billed and collected, current and YTD, from the TPL case-tracking system, by carrier.

C.6.12.3.7 Number and amount of recoveries by type; for example, estate, fraud collections, private insurance and the like.

C.6.12.3.8 Unrecoverable amounts by type and reason.

C.6.12.3.9 Potential trauma or accident claims, including those passing threshold allowances.

C.6.12.3.10 Services subject to potential recovery when date of death is reported.

C.6.12.3.11 Unduplicated cost-avoidance reporting by medical assistance program category and by type of service, with appropriate totals and subtotals.

C.6.12.3.12 Monthly listings of TPL carrier coverage data.

C.6.12.3.13 Audit trails of changes to TPL data.

C.6.12.3.14 Summary and detail reports on premiums paid.

C.6.12.3.15 Automated letters to carriers, recipients, and providers when recoveries are initiated, when TPL resource data is needed, or when accident information is required and was not supplied with the incoming claim.

C.6.12.3.16 Claim facsimiles to carriers, attorneys in recovery cases, or other parties.

C.6.12.3.17 On-line inquiry into TPL data.

C.6.12.3.18 On-line access to claims suspended for TPL errors, and on-line resolution of errors by assigned staff.

C.6.12.3.19 On-line report definition capability based on user selected criteria.

C.6.12.4 Interfaces

The TPL function interfaces with:

1. Governmental agencies data matching,
2. Private insurers data matching, and
3. Workers' compensation data matching.

C.6.13 LONG TERM CARE (LTC) PROCESSING

The purpose of the Long Term Care (LTC) Processing function is to support the processing of nursing home and other long-term care claims through the maintenance of recipient-specific nursing home data and provider-specific certification and rate data.

The District of Columbia MMIS LTC Processing function supports the District's objectives to:

1. Reimburse providers for long-term care services,
2. Efficiently administer and manage the District of Columbia long-term care programs through long-term care cost and utilization reports,
3. Monitor certification of long-term care facilities, and
4. Develop payment methodologies for long-term care services.

C.6.13.1 Inputs

The inputs to the LTC Processing function are:

1. Update transactions with placement level, facility, patient liability, and effective dates;
2. Provider-specific LTC data;
3. UB92s and HIPAA complaint format claims (X12N 837I) from providers; and
4. Recipient eligibility data from IMA including authorization status, level of care, provider number, and spend-down amount.

C.6.13.2 Processing Requirements

The LTC Processing function uses recipient-specific LTC data and LTC provider-specific data to produce UB92s and HIPAA complaint format claims (X12N 837I) from providers and remittance advice or HIPAA complaint X12N 835. In order to perform these functions, LTC processing shall:

C.6.13.2.1 Maintain date-specific LTC data by recipient, to include:

1. Admission and discharge dates,
2. Home leave of absence and hospital hold bed days, and
3. Patient financial liability information.

C.6.13.2.2 Maintain date-specific LTC data by provider (LTC facility) to include:

1. Reimbursement rate;
2. Certification date; and

3. Type of facility (for example, NF, ICF-MR).

C.6.13.2.3 Accept on-line updates to recipient nursing home data.

C.6.13.2.4 Maintain inquiry to recipient LTC data with access by recipient ID.

C.6.13.2.5 Maintain current and historical LTC data to support claims processing and reporting.

C.6.13.2.6 Generate X12N 835 and/or remittance advice.

C.6.13.2.7 Maintain an on-line claims processing suspense file of all monthly claims so that only additions, changes, and deletions made by the provider to the claims need to be resubmitted in standard format by the provider.

C.6.13.2.8 Update, in batch mode, recipient-related data on the LTC file from claims (for example, date of death).

C.6.13.2.9 Identify patient liability amounts, Medicare and other third-party resources, and deduct them from payments to providers.

C.6.13.2.10 Track patient liability amounts owed to the facility.

C.6.13.2.11 Track recipient leave and bed reserve days.

C.6.13.2.12 Provide processes and data to meet minimum requirements in Part 11 of the State Medicaid Manual.

C.6.13.3 Information Retrieval

At a minimum, the proposed system must be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information must be made available in report format, on-line, or through another medium as specified by the District.

C.6.13.3.1 The primary output of the LTC Processing function is remittance advice or HIPAA standard format X12N 835.

C.6.13.3.2 Reports generated by this function must include:

1. Analysis of leave days,
2. Discrepancies between patient liability amounts on the claims and on the LTC recipient data set,
3. Nursing facility rosters,
4. Patient liability amounts owed,
5. Hospital claims/bed-hold analysis/comparison,
6. Audit trail of changes to LTC data,
7. Patients identified with a date of death from claims, and

8. Reports for recoveries from estates indicating payments made by provider.

C.6.13.4 Interfaces

There are no external automated interfaces identified for the LTC Processing function.

C.6.14 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROCESSING

The EPSDT processing function serves as the District's mechanism to identify and track EPSDT services, and to generate notification letters to eligible recipients. The EPSDT processing function supports the District's goals of:

1. Providing District of Columbia medical assistance recipients under the age of 21 with a continuing system of health screenings and treatment services to permit early detection of potentially chronic or disabling health conditions,
2. Encouraging regular health care for these recipients to reduce the occurrence of more serious and costly health problems, and
3. Maximizing Federal funds for the provision of health care to District of Columbia eligible recipients under the age of 21.

The primary objectives of the automated EPSDT function of the MMIS are to:

1. Maintain identification of all individuals eligible for EPSDT services;
2. Establish automated procedures to support the initial notification of eligible, and periodic re-notification of non-participants and participants about the availability of EPSDT services;
3. Provide reports to meet Federal and District reporting requirements (CMS 416) and;
4. Other reports as required by the federal or local government and the courts.

The District is especially interested in enhanced reporting and tracking capabilities from the MMIS' EPSDT function. The ability to match recipient screenings to follow-up treatment and link health care costs for EPSDT eligible to specific conditions are some of the areas where enhanced reporting and tracking capabilities are desired.

C.6.14.1 Inputs

Inputs to the District of Columbia EPSDT function include:

1. Recipient demographics and program eligibility,
2. Periodicity schedules for ongoing notification,
3. Paid claims and managed care encounter data, and

4. Changes to the wording of notifications.

C.6.14.2 Processing Requirements

The District of Columbia MMIS shall support the EPSDT program through the operation of an EPSDT system with the following capabilities:

C.6.14.2.1 Identify EPSDT-eligible families, and automatically generate initial notices to newly eligible or reinstated families that inform them about the availability of EPSDT health screening and diagnostic services, and encourage them to participate.

C.6.14.2.2 Generate notices, based on the District periodicity requirements, to parents, guardians, or case heads of children participating in EPSDT, about the availability of screening and treatment services. This includes members who are enrolled in an HMO.

C.6.14.2.3 Generate annual notices to parents, guardians or case heads of non-participating, eligible children, about EPSDT services.

C.6.14.2.4 Maintain a process to allow on-line, real-time update to the text of notification letters.

C.6.14.2.5 Maintain all EPSDT program eligibility records, periodicity schedules, recipient notification and notification response dates, and screening dates.

C.6.14.2.6 Maintain, for each recipient, the EPSDT screening results, referrals and treatments for abnormal conditions identified during the screenings.

C.6.14.2.7 Accept on-line updates of notification responses, screening information, and periodicity schedules.

C.6.14.2.8 Provide on-line inquiry to EPSDT data with access by recipient ID.

C.6.14.2.9 Identify screening claims adjudicated during claims processing.

C.6.14.2.10 Identify abnormal conditions, by screening date, and whether the condition was treated or referred for treatment.

C.6.14.2.11 Track abnormal conditions, which have been referred but not yet treated, to claims, submitted for the recipient, until all abnormal conditions have been treated.

C.6.14.2.12 Update recipient EPSDT data with screening results and dates, and referral and treatment dates for abnormal conditions.

C.6.14.3 Information Retrieval

At a minimum, the proposed system shall be capable of retrieving data necessary to generate the following outputs and support the following information needs. Information must be made available in report format, on-line, or through another medium as specified by the District. To support the EPSDT processing function the system shall provide for:

C.6.14.3.1 Generation of the mandated Federal EPSDT report (CMS-416), in the federally required format, and including data from other District Agencies who provide EPSDT services.

C.6.14.3.2 Management reports which can be sorted by District Office, then ordered alphabetically by case head with children identified under case heads, and which detail the following:

1. Screenings performed;
2. Abnormalities found;
3. Immunizations delivered;
4. Dental procedures performed;
5. Referral treatments recommended and initiated;
6. Age groupings and geographic summaries of the above;
7. Summary notification reports;
8. Detail report of initial notifications sent by recipient ID within District office;
9. Summary screening and results reports;
10. Detailed EPSDT-related services reports, by recipient, on request;
11. Number of days between screening and referred treatment;
12. Screening cost analysis, by screening provider, showing utilization and expenditure data;
13. Expenditures for children who were screened compared to those who were not screened; and
14. Untreated abnormalities after 30 days and 60 days, by recipient.

C.6.14.3.3 Initial and periodic notification documents.

C.6.14.4 Interfaces

1. Interface with the District of Columbia EPSDT tracking System.
2. Interface with the Managed Care Organization for encounter claims.

C.6.15 QUALITY CONTROL/ASSURANCE

The Quality Control and Assurance function ensures that proper internal controls are included in the operation and management of the District of Columbia MMIS.

Quality control is the system of internal controls that the Contractor utilizes in the operation of the MMIS. Quality assurance is achieved through an MMIS test system (integrated test facility), which includes a test version of all on-line and batch programs and all MMIS files.

The integrated test facility (ITF) allows the District to monitor the accuracy of the MMIS and test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations.

C.6.15.1 Inputs

The inputs to the Quality Control/Assurance function are:

1. System control reports, and
2. Test claims and other test transactions.

C.6.15.2 Processing Requirements

The quality assurance function shall be supported by an MMIS with the capabilities to:

C.6.15.2.1 Accept test claims data submitted by the District on hard-copy or electronic media.

C.6.15.2.2 Identify test providers, recipients, and claims to maintain the integrity of routine claims processing operations and files.

C.6.15.2.3 Generate output, including files, reports, tapes, micro media, etc., to be separately identified and clearly labeled.

C.6.15.2.4 Perform claims processing in a simulated production environment.

C.6.15.2.5 Generate results on the functioning of tested edits or other conditions.
The quality control function shall be supported by an MMIS with the capability to:

C.6.15.2.6 Generate control reports for all necessary processes to track and validate records input, processed, and output, with exceptions noted.

C.6.15.2.7 Monitor system controls.

C.6.15.2.8 Provide a methodology to consistently validate internal balances and controls.

C.6.15.3 Information Retrieval

The Quality Control/Assurance function shall provide for:

1. Claims processing output from claims processing runs, to include reports, files, tapes, micro media, and so forth; and
2. Reports of the results of payment cycles.

C.6.15.4 Interfaces

There are no external automated interfaces identified for this function.

C.6.16 MANAGEMENT AND ADMINISTRATIVE REPORTING (MARS)

The purpose of the Management and Administrative Reporting (MARS) function is to provide programmatic, financial, and statistical reports to assist the District with fiscal planning, control, monitoring, program and policy development, and evaluation of the District of Columbia medical assistance program.

The MARS function is a comprehensive management tool that provides information on program status and trends, and has the capability to analyze these historical trends and predict the impact of policy changes on programs. This function uses key information from other MMIS functions to generate reports.

The major inputs to this area are data from all the claims processing functions and the Reference Data Maintenance, Recipient Data Maintenance, and Provider Data Maintenance functions. The major process is the generation of the reports, and the major outputs are the financial, statistical and summary reports required by Federal regulations, and other reports that assist the District in the administration of the District of Columbia medical assistance program.

This function must be flexible enough to meet both existing and proposed changes in format and data requirements of Federal statistical reporting without major reprogramming or expense, and provide maximum flexibility to accommodate future changes to meet the unique reporting needs of District of Columbia's medical assistance program. The District of Columbia will also require a special separate MARS reporting for encounter claims received from Managed Care Organizations.

The District's objective in the use of the Management and Administrative Reporting function is to receive:

1. Comprehensive information reported by program and authorizing agency;
2. Comparisons of current program activity with activity in prior periods;
3. Reports that indicate trends in the programs;
4. Reports that monitor the progress of claims submission and claims processing activity;
5. Summary reports which reflect the current status of claims payments;
6. Provider performance reports showing the extent of participation and service delivery with the capability to specify the performing provider;
7. Reports of recipient participation and program use analysis;
8. Separate reporting of all types of claim adjustments and non-claim-specific financial transactions;
9. Reports that meet all Federal and District financial and statistical reporting requirements; and
10. Reports in a form acceptable to the District and/or CMS, without manual intervention or manipulation of data.

The management reporting function shall meet all Federal MARS requirements in Part 11 of the State Medicaid Manual, effective on the operational start date.

C.6.16.1 Inputs

The MMIS shall accommodate the following inputs related to the MARS function:

1. Adjudicated claims data, suspended claims data, adjustments and financial transactions, for the reporting period, from all the claims processing functions and Financial Processing functions;
2. Reference data, for the reporting period, from the Reference Data Maintenance function;
3. Provider data, for the reporting period, from the Provider Data Maintenance function;
4. Recipient data, for the reporting period, from the Recipient Data Maintenance, LTC processing, EPSDT processing, and TPL processing functions;
5. Budget data; and
6. Financial data, for the reporting period, from the other sources (paper, tape, diskette) not available from the MMIS Financial Processing function.

C.6.16.2 Processing Requirements

The primary function of MARS, and one of the most important functions of the MMIS in general, is to generate useful and informative District and federally-required reports. These reports are described in more detail in Subsection C.6.16.3. To support production of reports, the system must be capable of the following processing activities:

C.6.16.2.1 Extract data monthly from other functions of the MMIS, build MARS master file(s), and create reporting extract files that are used to produce the monthly, quarterly, and annual MARS reports.

C.6.16.2.2 Compile subtotals and totals on all reports as appropriate.

C.6.16.2.3 Generate all reports on a monthly, quarterly, annual, semiannual and biannual basis, as specified by the District.

C.6.16.2.4 Provide the flexibility to change or add categories of service, special programs, recipient eligibility categories, provider types, and specialties and carry through corresponding changes in affected MARS reports without additional cost to the District.

C.6.16.2.5 Generate reports to include the results of all financial transactions, whether claim-specific or non-claim-specific.

C.6.16.2.6 Identify fraud and abuse recoupments and third-party liability collections separately when specified by DOH.

C.6.16.2.7 Meet all enhanced requirements for the Tape Reporting Option (MEDSTAT), including reporting of off-system payments and claiming of FFP, for the MSIS CMS-2082 and paper CMS-2082 that includes state-specific optional fields.

C.6.16.2.8 Maintain the integrity of data element sources used by the MARS reporting function and integrate the necessary data elements to produce MARS reports and analyses.

C.6.16.2.9 Maintain the uniformity and comparability of data through the MARS reports, and between these and other functions' reports, including reconciliation of all financial reports with claims processing reports.

C.6.16.2.10 Provide counts of services based on meaningful units, by service category, as defined by MAA (for example, days, visits, prescriptions, and so forth), counts of claims, and unduplicated recipient and provider counts.

C.6.16.2.11 Generate all reports in hard copy, tape, or diskette, as specified by MAA; all reports will be produced on fiche.

C.6.16.2.12 Track and report on expenditures funded by departments and programs outside of MAA, as well as by MAA.

C.6.16.2.13 Provide charge, expenditure, eligibility, and utilization data to support budget forecasts, tracking, and Medicaid modeling, to include:

1. Eligibility counts and trends by aid category;
2. Utilization patterns by recipient eligibility category, provider type, and category of service;
3. Charges and expenditures by category of service;
4. Lag factors between date of service and date of payment to determine cash flow trends; and
5. CMS-2082 data on diskette and paper, monthly and annually.

C.6.16.3 Information Retrieval

The MARS function shall have the capability to:

C.6.16.3.1 Provide information to support institutional rate and capitation fee setting.

C.6.16.3.2 Provide LTC reports to include details and summary information by nursing home, on rates, patients, days, and payments for the current period and year-to-date.

C.6.16.3.3 Generate all specifically designated Federal (CMS) reports and reports necessary to meet reporting guidelines in Part 11 of the State Medicaid Manual.

C.6.16.3.4 Produce reports that show:

1. Time frames for claims, adjustments, and financial transactions are within the timely processing guidelines specified in District and Federal regulations;
2. Claim filing information based on comparisons of date of service to date of receipt;
3. Types and numbers of errors occurring during claims processing (suspended claim analysis) by provider, provider type, and category of service;
4. Expenditures by service type showing service provided, recipients, and units of service;
5. Claims throughput analysis;
6. Comparisons of actual claim expenditures to projected budgeted amounts and budget variations;
7. Comparisons of past, current, and future financial trends by recipient eligibility category and category of service;
8. Current provider payment amounts;
9. Average cost per eligible and per recipient;
10. Historical trends of payments and average costs;
11. The amount of financial liability against the program, including in-process claims, retroactive TPL recoveries and adjustments;
12. Recipient participation analysis and summary, showing utilization rates, payments, and number of recipients by eligibility category;
13. Provider participation analysis and summary, showing payments, services, category of service, and recipient eligibility categories;
14. Utilization of services against benefit limitations;
15. Expenditure data, by procedure code, to assist in determining reimbursement methodologies;
16. Waiver and special program participation and expenditure data, including services, payments, billed amounts, eligibles, unduplicated recipient counts, and total cost of care by date of service and federally required waiver reports, by waiver;

17. TPL and cost-settlement analysis, including billings and collections;
18. Procedure usage analysis by recipient aid category, age, provider type, and category of service;
19. Geographic (District location) participation and expenditure analysis and summaries;
20. Claims paid for by service, such as abortion, sterilization;
21. Providers ranked by payment amount and other factors;
22. Paid, suspended, denied, and duplicate claim statistics, by provider type, category of service;
23. Monthly aggregate data on units of service by provider type and category of service; and
24. Claims paid by specific diagnosis.

C.6.16.4 Interfaces

There are no external interfaces currently identified for this function.

C.6.17 SURVEILLANCE AND UTILIZATION REVIEW (SUR)

The Surveillance and Utilization Review function supports the investigation of potential misuse of the Medical Assistance program by providers and recipients. It analyzes historical data and develops profiles of health care delivery, and reports those users whose patterns of care or utilization deviate from established normal patterns of health care delivery.

This function serves as a management tool to allow the District to evaluate the delivery and utilization of medical care, on a case by case basis, to safeguard the quality of care, and to guard against fraudulent or abusive use of the District of Columbia medical assistance programs, by either recipients or providers.

The objectives of the Utilization Management Reporting function are to:

1. Establish a comprehensive profile of health care delivery and utilization patterns established by provider and recipient participants, in various categories of services, under the District of Columbia medical assistance program;
2. Provide information for the investigation of misutilization of District of Columbia's medical assistance program, by individual participants, and promote correction of actual misutilization;
3. Provide information to facilitate the investigation of potential defects in the level of care and quality of service provided under the District of Columbia medical assistance program;

4. Produce reports which are responsive to the changing administrative and management needs of the District of Columbia medical assistance program; and
5. Provide data to detect edit/audit or policy failures.

C.6.17.1 Inputs

The inputs to the Surveillance and Utilization Review function include data from other MMIS functions to be used in reporting:

1. Claims history;
2. Managed care encounter history;
3. Provider demographic and enrollment data;
4. HMO provider network demographic and enrollment data;
5. Recipient demographic and eligibility data; and
6. Reference data for descriptions of diagnosis, procedure, and drug codes.

Primary inputs are user-maintained parameters which define report processes and content. For purposes of this RFP, this set of parameters will be generically referred to as the control file.

The District of Columbia mandates that all TANF recipients be enrolled in an HMO. As a result, the SURS proposed shall incorporate HMO encounter data and HMO network providers who are not enrolled as fee for service MMIS providers. For the purpose of this RFP, all references to claims in subsection C.6.17 shall mean claims and encounters. Similarly all references to providers in this subsection shall mean MMIS providers and HMO network providers.

C.6.17.2 Processing Requirements

In order to support the manual functions of investigation and follow-up action of potential cases of misutilization, the SUR function must have the capabilities to:

C.6.17.2.1 Maintain access to claim and encounter history files and extract data, according to District parameters on the SUR control file, for reporting.

C.6.17.2.2 Generate statistical profiles, by providers and recipients, summarizing information contained in claims and encounters history submitted by each provider over a specified period of time.

C.6.17.2.3 Provide a methodology to classify recipients into peer groups using user-defined criteria such as age, sex, race, living arrangement, geographic region, aid category, special programs indicator, fund category, placement level, and LTC indicator for the purpose of developing statistical profiles.

C.6.17.2.4 Provide a methodology to classify providers and HMO network providers into peer groups using criteria such as category of service, provider type, specialty, type of practice/organization, enrollment status, facility type, geographic region, billing vs. performing provider, and size for the purpose of developing statistical profiles.

C.6.17.2.5 Provide a methodology to classify treatment into peer groups, by diagnosis or range of diagnosis codes, for the purpose of developing statistical profiles.

C.6.17.2.6 Maintain flexibility to classify inpatient treatment into peer groups, by level of care or other methodology.

C.6.17.2.7 Maintain data on the most recent 15 months of claims and adjustments, by date of service, to generate reports.

C.6.17.2.8 Generate statistical norms, by peer group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles; the District may use these norms to set exception limits.

C.6.17.2.9 Maintain a process to evaluate the statistical profiles of all individual providers or recipients within each peer group against the matching exception criteria established for each peer group.

C.6.17.2.10 Identify providers and recipients who exhibit aberrant practice or utilization patterns, as determined by an exception process, comparing the individuals' profiles to the limits established for their respective peer groups.

C.6.17.2.11 Maintain a parameter-driven control file that allows the District to specify data extraction criteria, report content, parameters, and weighting factors necessary to properly identify aberrant situations.

C.6.17.2.12 Identify waiver services on recipient and provider reports.

C.6.17.2.13 Maintain data necessary to support managed care of special interest populations.

C.6.17.2.14 Provide referral processing to bring data on services ordered by a physician or case manager/gatekeeper from inpatient, pharmacy, independent labs, and physician claims into the referring providers' profiles.

C.6.17.2.15 Generate profiles for group billers and individual rendering providers separately, based on group provider claims.

C.6.17.2.16 Generate lists of providers and recipients who are found to be exceptional, ranked in order of severity.

C.6.17.2.17 Provide a process to select and print claims data at the request of the user, in such a way that sufficient information is available to make a determination of misutilization, and such information is displayed for the user.

C.6.17.2.18 Generate frequency distributions, as defined by the users.

C.6.17.2.19 Maintain a process to apply weighting and ranking to exception report items to facilitate the identity of the highest deviators.

C.6.17.2.20 Maintain a process to link all services rendered to nursing home residents while resident in, or on leave days from, a facility, by facility ID.

C.6.17.2.21 Print a description of all procedure, drug, and diagnosis codes on all reports.

C.6.17.2.22 Provide on-line access to SURS history and summary files, to include summary utilization data (number of services, amount billed, amount allowed, amount paid, average paid per code), by procedure or diagnosis code for individual providers or recipients, or other selection criteria.

C.6.17.2.23 Provide help screens to identify codes and values of data elements, and to facilitate user access to and manipulation of SUR information.

C.6.17.2.24 Provide the ability to combine with claims data, or segregate, encounter data on all profiles and claim detail reports.

C.6.17.3 Information Retrieval

The District of Columbia MMIS shall meet all Federal and District SUR reporting and information retrieval requirements. All reports shall be available on paper and fiche, at a minimum. Retrieval of information on-line or in another media shall be available when specified by the District. The SUR information retrieval function shall provide for the following:

C.6.17.3.1 Management summary reports, by peer group, to include:

1. Summary Matrix Item Totals;
2. Frequency Distributions; and
3. Exception Report Item Totals, including norms, exception limits, and number of exceptions.

C.6.17.3.2 Profile reports, including:

1. Recipient Exception Profiles,
2. Provider Exception Profiles,
3. Recipient Summary Profiles (non-excepting), and
4. Provider Summary Profiles (non-excepting).

C.6.17.3.3 Other reports, including:

1. Supporting reports,
2. Claim Detail Reports,
3. Special Reports,
4. Severity Index Report, and
5. Control File Reports.

C.6.17.3.4 Detail of paid services, with sufficient information to facilitate analysis of data for the most recent 15 months of paid claims, for selected providers and recipients, reported on a monthly basis.

C.6.17.3.5 Claim detail, with multiple select and sort formats, which shall include but not be limited to:

1. Provider ID and name;
2. Provider specialty;
3. Recipient ID and name;
4. Referring/prescribing provider ID;
5. Category of service;
6. Date or date range of service;
7. Payment date;
8. Place of service;
9. Diagnosis code(s), with description;
10. Procedure/drug code(s), with description;
11. Therapeutic class code(s);
12. Drug generic code(s);
13. Lock-in indicator;
14. Billed and paid amounts; and
15. Brand certification.

C.6.17.3.6 Within a single report, ambulatory and inpatient services provided to nursing home residents, by long-term care facility.

C.6.17.3.7 LTC summary report, which lists the following for each facility:

1. Facility characteristics and data,
2. Number of recipients served by each performing provider,
3. Dollars paid to each performing provider for services to LTC recipients, and

4. Dates of service.

C.6.17.3.8 LTC detail report, which includes:

1. Names and IDs of recipients using inpatient services during an LTC confinement,
2. Hospital stay dates of service, and
3. Amount billed per hospital stay.

C.6.17.3.9 A detail report which identifies the number of services to LTC facilities, by performing providers, by provider number, and gives details for recipients, including date of service, procedure code, and amount billed.

C.6.17.3.10 Annual ranking by dollars for the top 100 recipients, by diagnostic group and/or payment amount.

C.6.17.3.11 Quarterly identification of the medical services in which overutilization is most prevalent.

C.6.17.3.12 Summary and detail information on hospital stays, including length of stay, room and board charges, ancillary charges, and medical expenses prior to and immediately following the hospital stay.

C.6.17.3.13 Reports, as specified by the District, which identify all services received by recipients who are receiving a specific treatment or drug, are enrolled in certain programs, have a certain living arrangement, or are receiving services from certain providers or provider groups.

C.6.17.3.14 Capability to force profiling of selected providers or recipients.

C.6.17.3.15 Weighting and ranking of exceptions.

C.6.17.3.16 Narrative descriptions of procedures, drugs, and diagnoses on reports.

C.6.17.3.17 Extensive use of claim data elements for summary item definition.

C.6.17.3.18 Definition of unique report groups for every user-defined category of service.

C.6.17.3.19 User-specified selection, summarization, and induplication criteria for claim details.

C.6.17.3.20 Identification of recipients receiving services from different, user selected, providers or provider types, on the same or overlapping dates of service.

C.6.17.3.21 Cross referencing of multiple provider rendered to one recipient with the same date of service.

C.6.17.4 Interfaces

There are no external interfaces currently identified for this function.

C.6.18 HOME AND COMMUNITY BASED CARE (HCBC) PROCESSING

The MMIS shall process claims submitted on behalf of recipients authorized to receive services under District of Columbia's two HCBC Programs, Elderly and Mentally Retarded/Developmentally Disabled (MR/DD). Recipients covered under these waiver programs may receive benefits not otherwise available through the Medicaid Program, for example, case management services. Further, service limitations normally applicable in the District of Columbia Medicaid Program may not apply in the waiver Programs. Consequently, the MMIS must maintain specialized processing capabilities in support of HCBC.

C.6.18.1 Inputs

Inputs to the HCBC processing function shall include:

1. Recipient eligibility data,
2. Provider eligibility data,
3. Reference data, and
4. HCBC claims submitted to the MMIS for payment.

C.6.18.2 Processing Requirements

The MMIS shall have the capability to:

C.6.18.2.1 Identify recipients who are authorized to receive HCBC services.

C.6.18.2.2 Verify that the provider submitting a HCBC claim is enrolled in the Program as a HCBC provider as well as a regular Medicaid provider, and is billing the HCBC service under the HCBC provider number.

C.6.18.2.3 Enroll the District agencies, School Districts, and other non-medical entities, as HCBC providers.

C.6.18.2.4 Maintain reference data to support HCBC processing, including but not limited to HCBC service prices, HCBC service limits, and HCBC services authorized for a recipient.

C.6.18.2.5 Apply frequency and duration limits on waiver program services in accordance with HCBC authorizations.

C.6.18.2.6 Track recipient use of HCBC services.

C.6.18.2.7 Maintain the capability to identify and recoup from case managers who have received payment for services to a HCBC recipient following the date of death.

C.6.18.3 Information Retrieval

The system shall be able to retrieve information in support of the HCBC Programs in report format, on-line, or through another media specified by the District. The following types of information are required:

1. Services provided under waiver programs, presented in such a way that it can be distinguished from information on the same services provided to non-waiver recipients;
2. Information which compares the cost of providing care to target populations under waiver programs with comparable populations in non-waiver settings;
3. Information which supports the identification of comparable populations to which waiver program eligibles may be compared; and
4. Federal and District HCBC reports, including the CMS -372 S generated on the schedule and in the format acceptable to the federal or District agency, with format and frequency easily adjustable as requirements change.

C.6.18.4 Interfaces

There are no external interfaces currently identified for this function.

C.6.19 CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) SUPPORT

Federal regulations require that payment of laboratory services may be made under the Medicaid Program only if those services are furnished by a laboratory that meets CLIA conditions. CLIA will regulate previously unregulated laboratory services, including those performed in physicians' offices. To receive Medicaid payment for laboratory services, entities performing the services will have to obtain CLIA certification and/or meet other CLIA conditions.

The subsections that follow describe CLIA requirements.

C.6.19.1 Inputs

Inputs to the CLIA support function are:

1. Provider eligibility data, including CLIA certification indicator, level, and CLIA ID number;

2. Reference data, including identification of laboratory services on any CLIA list of wavered tests, and CLIA level codes for types of tests; and
3. Laboratory claims submitted to the MMIS for payment.

C.6.19.2 Processing Requirements

The MMIS shall have the capability to:

1. edit laboratory services against provider certification to perform the specific service, and
2. edit laboratory services against time limited CLIA certification data to determine validity on date of service.

C.6.19.3 Information Retrieval

At a minimum, the system shall be able to retrieve or report information that supports successful implementation and monitoring of CLIA requirements. Such information includes numbers of services; numbers, identity, and types of providers; providers grouped by CLIA level of certification; payment data, and financial data.

C.6.19.4 Interfaces

The CLIA interface function shall accommodate interface needs with the CMS OSCAR file.

C.6.20 HMO AND BROKER INTERFACE

C.6.20.1 Inputs

The following inputs to the HMO and Enrollment Broker interface function are required:

C.6.20.2 Processing Requirements

The MMIS shall provide processing capabilities to support the HMO and Enrollment Broker interface

C.6.20.3 Information Retrieval

The system shall be able to retrieve information in support of the HMO and Enrollment Broker interface in report format, on-line, or through another media specified by the District.

C.6.20.4 Interfaces

The HMO and Enrollment Broker interface function must accommodate interface needs with the following:

Provide the enrollment broker with the necessary data to insure accurate enrollment and dis-enrollment

Receive from the Broker and edit all HMO enrollment/dis-enrollment transactions and respond with electronic confirmation or denial transactions.

Provide HMO' s with rosters and payment reports to enable them to verify their membership.

Generate prospective capitation payments to managed care providers on a by-weekly or monthly schedule to be approved by MAA.

C.6.21 DRUG REBATE PROCESSING

Federal regulations provide for drug manufacturers, with whom CMS has a formal Contract and whose drug products are covered by Medicaid, to give financial rebates determined by the volume of the manufacturer's products dispensed by the Program. District of Columbia requires the MMIS Contractor to perform certain administrative activities necessary to carry out the federal mandates related to drug rebate processing.

C.6.21.1 Inputs

Inputs to the drug rebate processing function are:

1. Data from CMS which identifies manufacturers with whom rebate Contracts exist,
2. Data from CMS which updates manufacturer information,
3. Paid claims data, and
4. Reference data.

C.6.21.2 Processing Requirements

The MMIS shall be capable of the following:

1. Maintaining and updating data on manufacturers with whom rebate Contracts exist, including:
   a) Manufacturer ID numbers; and
   b) Contact name and address for manufacturer;
2. Validating units of measure from CMS file to MMIS drug file for consistency;
3. Producing rebate adjustments based on retroactively corrected CMS rebate data;
4. Determining, from paid claim data, the amount of rebates due, and generating invoices; and

5. Tracking and updating rebate amounts due and received through an accounts receivable mechanism.

C.6.21.3 Information Retrieval

The MMIS shall retrieve information and produce outputs necessary to support effective implementation of the drug rebate processing function. At a minimum, this shall include:

1. Information needed to account for exceptions in calculating rebate amounts, such as drugs not covered for reasons related to DESI or IRS status, uncovered over-the-counter drugs, and the like;
2. Generation of invoices;
3. Reports, at least weekly or on request, which display current accounts receivable information; and
4. Reports and on-line information necessary to support dispute resolution when manufacturers and the District differ with respect to calculation of rebate amounts.

C.6.21.4 Interfaces

Ability to generate manufacturers invoices on disk and paper based on manufacturer's preference.

C.6.22 DRUG UTILIZATION REVIEW (DUR)

The Drug Utilization Review (DUR) function provides for a retrospective review of drug utilization by recipients. Prospective DUR is performed by the existing Pharmacy Benefits Management and Point of Sale ((PBM/POS) Contractor. Retrospective DUR provides a methodology to monitor recipients who receive multiple drug prescriptions with indications of possible drug interaction conflicts, to monitor the pharmacists and providers who are dispensing and ordering drugs, and to monitor recipients' patterns of utilization, for detecting inappropriate drug therapies.

The retrospective DUR function shall be implemented and operated by the Contractor. It shall rely on information stored in and retrieved from the MMIS to provide for the periodic examination of provider dispensing patterns and recipient use of drugs. Data on drug use shall be assessed against predetermined standards set by the District that have been derived from various compendia and medical literature. The Contractor's retrospective DUR activities will be overseen by a District.

The objectives of the DUR system in District of Columbia are to:

1. Promote efficiency and cost-effectiveness in the use of pharmaceutical services,
2. Eliminate unnecessary and/or inappropriate use of drugs and help identify possible inappropriate drug therapy patterns,

3. Develop therapeutic class criteria to reduce the incidence of drug therapy failure and drug-induced illness, and
4. Establish and maintain drug history profiles.

C.6.22.1 Inputs

The inputs to the Drug Utilization Review function include:

1. DUR standards set by the District,
2. Claims history data,
3. Recipient data,
4. Provider data,
5. Reference data, and
6. DUR reporting parameters.

C.6.22.2 Processing Requirements

The DUR function must meet the minimum specifications of the published Federal DUR regulations and OBRA 90. Contractors may propose processing capabilities beyond those identified in this subsection. At a minimum, the DUR system shall have the following capabilities:

1. Track and analyze drug therapies, by categories of high-risk disease, to include, but not be limited to:
   a) Cardiovascular disease;
   b) Cerebrovascular disease;
   c) Central nervous system disease;
   d) renal disease;
   e) Endocrine disease;
   f) Gastrointestinal disease; and
   g) Psychiatric illness;
2. Track and analyze drug regimens by therapeutic classes of drugs;
3. Identify problems associated with inappropriate drug use, to include:
   a) Underutilization;
   b) Over utilization;
   c) Drugs contraindicated by diagnosis;
   d) Drugs contraindicated by the presence of other drugs;
   e) Iatrogenic complications;
   f) Adverse drug reactions;

g) Treatment failure; and

h) Brand certification;

4. Identify patterns in the use and cost of drugs by providing drug use profiles, by recipient and provider, to include items such as:

   a) Recipient name and ID;

   b) Recipient age and sex;

   c) Nursing home ID;

   d) Inpatient diagnosis codes;

   e) Outpatient/ambulatory diagnosis codes;

   f) Dates of service;

   g) Provider numbers (for example, hospital, pharmacy, physician, primary care);

   h) Provider type code;

   i) prescriber ID;

   j) Drug code and description;

   k) Drug strength;

   l) Dosage form;

   m) Quantity dispensed;

   n) Brand certification;

   o) Days supply; and

   p) Prescription number;

5. Maintain a set of parameters to control the production of profiles based on category of disease, drug class, or other parameters;

6. Flag individual recipients and providers as exceptional according to District-specified criteria; and

7. Generate management-level reports on drug utilization.

C.6.22.3 Information Retrieval

The proposed system shall retrieve information and produce outputs that include:

1. Annual reports required by CMS,

2. Recipient and provider profiles,

3. Management reports, and

4. Updated parameter data set.

C.6.22.4 Interfaces

No external automated interfaces have been identified for this function.

C.6.23 Transportation Broker

The Non Emergency Transportation Broker must perform in managing and administering the Comprehensive Non-Emergency Transportation program. It also clearly defines the expected level of service the District of Columbia is pursuing, as well as outlines the broker's responsibilities supporting the NET program.

C.6.23.1 The Contractor shall agree to do the following:

C.6.23.1.2 Provide the Broker with a list of eligible clients that the Broker will systematically assign to transportation providers for transport to Medicaid covered healthcare services in the District of Columbia.

C.6.23.1.4 Provide the transportation broker with the necessary data to insure accurate enrollment and dis-enrollment.

C.6.23.1.5 Receive from the Broker and edit all enrollment/dis-enrollment transactions and respond with electronic confirmation or denial transactions.

C.6.23.1.6 Provide the broker with rosters and payment reports to enable them to verify their membership.

C.6.23.1.7 Generate prospective capitation payments to the broker care providers on a by-weekly or monthly schedule to be approved by MAA.

C.6.23.1.8 Pay the Broker according to the terms specified in the forthcoming contract.

C.6.23.1.9 The Contractor shall provide MMIS access to the broker via a high speed links to the broker facility.

C.7 DESIGN, DEVELOPMENT AND IMPLEMENTATION OF ENHANCEMENTS TASK REQUIREMENTS

C.7.1 Project administration activities include the set-up of all the internal management processes for the Contractor and its subcontractors, as well as the implementation of all department and Contractor management processes and reporting requirements. The objective of these controls is to ensure the smooth administration of the project. Contractors shall propose an approach to design, development, and implementation of enhancements and project administration that includes and describes the following activities that shall be in effect throughout the life of the contract:

C.7.1.1 Installation, testing, and successful operation with simulated data of an un-enhanced test version of the MMIS system that the Contractor is licensing.

C.7.1.2 Design, development, and implementation of enhancements to the MMIS to be placed in the operational start date as defined in Paragraph H.37.6.

C.7.1.3 A proven system development methodology for use in phased delivery of systems enhancements.

C.7.1.4 Formal status reporting procedures and schedules;
Issue identification, tracking, reporting and resolution procedures, including an automated tracking and management system with the information captured and tracked to be subject to the state's approval;

C.7.1.5 Change control procedures;

C.7.1.6 Management of subcontractor relationships, to ensure high quality performance of all subcontractor functions; and

C.7.1.7 Personnel management functions, including hiring and firing and employee relocation.

C.7.2 Where appropriate, the use of automation to facilitate these activities is encouraged. The Contractor shall present all project work plan material to the District utilizing MS Project in the version that is currently the standard for the District of Columbia. All work plans shall be provided to the District in both hardcopy and electronic format.

C.7.3 The Contractor shall describe the project management approach for planning, organizing, and managing the staff and activities throughout the life of the project. The Contractor's project management approach shall facilitate open and timely communication with the MAA and a strong working relationship to achieve the overall goal of satisfactory performance within budget.

C.7.4 The work to be performed by the Contractor during the Enhancement and Implementation of Enhancements Task (repeating three times, once for each phase) shall be organized under five (5) major subtasks: Design Subtask, Development/Testing Subtask, Conversion Subtask, Acceptance Testing Subtask, and Implementation Subtask.

C.7.5 The schedule of key dates and dates for submittal of major deliverables for District review during the Enhancement and Implementation task shall be set by the Contractor in the work plan. All milestone dates and key dates are contingent upon District approval. The primary considerations are that (1) the Contractor shall allow a minimum of eight (8) weeks for user acceptance testing, including the operational readiness test, and (2) the start of operations must be on or before the Operational start date as defined on Paragraph H.37.6 Operational Start Date – PERFORMANCE REQUIREMENTS.

C.7.6 Each subtask in the Enhancement and Implementation Task is described in terms of:

1. Requirements,
2. District responsibilities,
3. Contractor responsibilities,
4. Deliverables, and
5. Milestones.

C.7.6.1 The material that shall be presented in each of the five areas above, for all subtasks included in Enhancement and Implementation, as described below.

C.7.7 Requirements

The requirements are mandatory activities for the given subtask. There are a number of activities that reoccur in every subtask. The standard Contractor requirements and activities for every subtask within the Enhancement and Implementation Task are:

C.7.7.1 Prepare an outline and obtain approval from the District for the contents and format for each deliverable before beginning work on the deliverable;

C.7.7.2 Obtain written approval from the District on the final deliverables for this subtask;

C.7.7.3 Revise deliverables, if required, using District review findings to meet content and format requirements;

C.7.7.4 Report progress against the work plan for a subtask by weekly written status reports and at weekly review meetings with the MMIS Coordinator and through a biweekly updated work plan/subtask schedule;

C.7.7.5 Deliver written status reports and updated work plans/schedules at 12 noon, one (1) work day before the status meeting; and

C.7.7.6 Identify scope of work issues seeking District approval before commencing work outside the scope of the RFP.

C.7.8 District Responsibilities

The responsibilities of District personnel are stated for each of the five (5) subtasks described in Section C.7.4. There are a number of activities that reoccur in every

subtask. The standard District responsibilities for every subtask within the Enhancement and Implementation Task are:

C.7.8.1 Review and approve the proposed format and content of all subtask deliverables;

C.7.8.2 Review Contractor deliverables, determine the approval status of the deliverable, and provide written comments to the Contractor within five (5) working days;

C.7.8.3 Conduct weekly status meetings with the Contractor to review progress against the work plan;

C.7.8.4 Review weekly written status reports and biweekly work plan/subtask schedule updates;

C.7.8.5 Monitor Contractor progress to task milestones; and

C.7.8.6 Analyze, authorize, and add to the contract, any approved changes to the Scope of Work as described in this RFP.

C.7.9 Contractor Responsibilities

C.7.9.1 The responsibilities of the Contractor are identified for each of the five (5) subtasks. In addition, the Contractor has overall responsibility for the timely and successful completion of each of the subtasks. The Contractor is responsible for clearly specifying and requesting information/data from the District in such a manner as not to delay any part of the schedule.

C.7.9.2 The Contractor's proposed approach to assuming this overall responsibility and the specific responsibilities of each of the subtasks will be considered by the District. The approach to coordinating the responsibilities of the District with those of the Contractor to ensure overall project success shall be addressed.

C.7.10 Deliverables

C.7.10.1 All deliverables for the Enhancement and Implementation Task shall follow the Rational Unified Process or another process agreed to by the District and meet District-approved format and content requirements.

C.7.10.2 Deliverables for the Enhancement and Implementation Task include:

1. Requirements Specification Document,
2. Detailed Work Plan,
3. Detailed System Design,
4. Unit and System Test Plan,
5. Program codes
6. Operating system, Job Control Language, Scripts, Macros,

7. Unit and System Test Results,
8. MMIS User Manuals,
9. MMIS Operating Procedures,
10. Provider Manuals,
11. Disaster Recovery Plan,
12. Revised Detailed System Design,
13. Conversion Plan,
14. Conversion Test Results,
15. Preliminary Converted Files,
16. Acceptance Test Resolutions Document,
17. Final MMIS User Manuals,
18. Final Provider Manuals,
19. MMIS Systems Documentation,
20. MMIS Implementation Plan,
21. District Training Plan,
22. Provider Training Plan, and
23. Results of Final File Conversion.

C.7.10.3 Each Contractor deliverable shall be delivered in five (5) copies, and shall be reviewed by the Department, and will require formal approval from the Department. The Contractor shall include at least five (5) working days, per deliverable, in the project work plan for District staff to complete a review of each deliverable and to document their findings. Based on the review findings, the Department may grant approval, reject portions of the complete document, or request Contractor revisions be made. Additional five (5) working day periods shall be required by the District whenever revisions are requested or a deliverable is disapproved**.**

C.7.11 Milestones

C.7.11.1 Project milestones are listed for each task. Each milestone denotes a checkpoint toward the operations start date.

C.7.11.2 For every deliverable, the highest level milestones will be planned to be no more than 60 calendar days apart. For the lowest level deliverables, they will be no more than 5 working days apart.

C.7.11.3 The dates for completion of the milestones shall be identified in the Contractor's proposal and reflect key dates specified by the Contractor. At a minimum, key dates to be specified in the work plan are:

1. District approval of the deliverables for each of the three phases.
2. District approval of all Design Subtask milestones;
3. District approval of all Development/Testing Subtask milestones;
4. District approval of all Acceptance Test Subtask milestones;
5. District approval of all Conversion Subtask milestones;
6. All preparation for MMIS Operations and Claims Processing Milestone
7. District-approved Contractor start of full MMIS operations, including all reporting functions; and
8. Receipt of written approval for Federal certification of the District of Columbia MMIS.

C.7.11.4 Milestone and key dates shall be included as part of the contract. The Detailed Work Plan, prepared as part of the Design Subtask, will be used for performance standards, payment incentives, and implementation checkpoints. Payment for major activities within the Enhancement and Implementation Task shall be conditional upon successful achievement of milestones.

C.7.11.3 Because failure to meet any milestone completion date is a signal to the Department that a key date has not or will not be met, the Department will monitor each milestone completion date to ensure that the operations start date will be met.

C.7.12 ENHANCEMENT DESIGN SUBTASK

C.7.12.1 The objectives of the Design Subtask are to:

1. Gain an understanding of the District of Columbia medical assistance program environment,
2. Validate and refine the system requirements specified in this RFP through Joint Application Design (JAD) sessions and/or interviews,
3. Refine and finalize the work plan required as part of the Contractor's technical proposal, and
4. Develop the detail design of the District of Columbia MMIS.

C.7.12.2 This subtask will result in a Requirements Specification Document (RSD); a Detailed Work Plan, reflecting the required Enhancement and Implementation Task activities; and a Detailed System Design (DSD) document.

C.7.13 Design Subtask Requirements

The Contractor shall establish work space in the District of Columbia to conduct Design Subtask activities; the District will not provide work space for this task.

C.7.14 District Responsibilities

C.7.14.1 District responsibilities for requirements definition activities are:

1. Provide all available relevant documentation on current MMIS operations;
2. Clarify, at the Contractor's request, Medical Assistance Administration and Department of Health policy, regulations, and procedures;
3. Determine or develop policy, where necessary;
4. Make staff available to participate in the definition of detailed system and operational requirements;
5. Determine the frequency, intent, format, media, and numbers of copies for all reports; and
6. Meet with Contractor staff, as necessary, to finalize MMIS requirements.

C.7.14.2 District responsibilities for detail design activities are:

1. Review and approve (or request modification of) screens, reports, edit criteria, and record contents;
2. Review policies and develop additional fee schedules and reimbursement criteria, as needed;
3. Provide copies of all current files, as requested, to support conversion activities; and
4. Attend walk-through during the DSD to enhance understanding of the MMIS and to facilitate the approval process.

C.7.15 Design Subtask Contractor Responsibilities

Contractor responsibilities for requirements definition activities are as follows.

C.7.15.1 Become familiar with District of Columbia Medicaid and other medical program policies, services, and administration, as well as District of Columbia MMIS requirements, through interviews with District staff and reviews of documentation.

C.7.15.2 Validate the requirements in this RFP.

C.7.15.3 Conduct interviews with District staff to finalize requirements and the changes to ensure that responses to all RFP requirements are acceptable to the District. This may entail changes to screen or report layouts or system functionality.

C.7.15.4 Define the MMIS by identifying functions within and across subsystems, subsystem integration, internal and external interfaces, system files, and the processing architecture.

C.7.15.5 Prepare the Requirements Specification Document (RSD) deliverable meeting the requirements specified in subsection C.7.16.

C.7.15.6 Prepare a Detailed Work Plan, defining each task, subtask, activity, and completion date for each, and incorporating all District subtasks and activities. Detailed Work Plan content requirements are specified in Subsection C.7.16.2.

C.7.15.7 Contractor responsibilities for detail design activities include the following:

C.7.15.7.1 Revise and develop screen and report layouts, edit criteria, and file and record contents to reflect District of Columbia requirements. In developing screen, record, or other layouts the Contractor must perform prototyping to enable District staff to review and approve designs prior to their becoming final.

C.7.15.7.2 Prepare the Detailed System Design (DSD) deliverable, meeting the requirements as defined in Subsection C.7.16.3; the District will accept "staggered" delivery of the DSD as long as the whole document is complete by the date identified in the approved work plan.

C.7.15.7.3 Conduct walk-through and demonstrations during the DSD to enhance District understanding and to facilitate the approval process. Ongoing presentation of screen and report layouts and obtaining District approval during DSD development will facilitate overall District approval. The conduct of walk-through or demonstrations must not result in any additional cost to the District, including travel costs.

C.7.15.7.4 General Contractor responsibilities for this task are as follows:

C.7.15.4.1 Select and establish a site in District of Columbia where subsequent Enhancement and Implementation Task and Operations Task functions will be performed.

C.7.15.7.5 Deliverables

There are three (3) deliverables defined for the Design Subtask: Requirements Specification Document, Detailed Work plan, and Detailed System Design. Minimum requirements for each document are presented below.

C.7.16 Requirements Specification Document

C.7.16.1 The RSD will take proposal requirements, validate them, and identify how and where the requirements are met in the MMIS design. At a minimum, the RSD shall include:

1. A cross-walk or map of each functional requirement to a subsystem(s) and process(es);
2. An overview of the system architecture and how components are integrated to meet RFP requirements;
3. An identification of all internal and external interfaces;
4. An identification of linkages across functions;
5. An identification of system files and processing architecture;
6. A general narrative of the entire system and the flow of data through the system;
7. A general narrative of each subsystem, describing functions, features, and processes;
8. A flow diagram of each subsystem, identifying all major inputs, processes, and outputs of the subsystem;

9. A list of major data elements for each permanent data store; and
10. Lists of all inputs and outputs, by subsystem.

C.7.16.2 Detailed Work Plan

C.7.16.2.1 The Contractor shall provide a Detailed Work Plan before the Design Subtask. The purpose of the work plan is to identify Contractor delivery dates, to detail work activities, and to facilitate the District's monitoring of Contractor progress based on milestones and key dates as specified in Subsection C.7. The work plan shall be updated on a biweekly basis. At a minimum, the Detailed Work Plan shall include:

1. Key dates, and dates for submittal of deliverables;
2. Structure, using a breakdown of activity, task, subtask, and sub-subtask work steps within each of the major Enhancement and Implementation Task subtasks: Design, Development/Testing, Conversion, Acceptance Testing, and Implementation;
3. Description at the subtask level which includes:
   a) Description of the subtask;
   b) Proposed location for tasks to be performed;
   c) Definition of a work product;
   d) Personnel resources applied by name and level of effort, in hours;
   e) District resource requirements;
   f) Duration of task;
   g) Dependencies;
   h) Assumptions;
4. Deliverables;
5. Contingency and recovery procedures at the activity level;
6. Gantt chart;
7. PERT or dependency chart; and
8. Resource (personnel) matrix by subtask, summarized by total hours by person, per month.

C.7.16.3 Detailed System Design (DSD)

C.7.16.3.1 At a minimum, the DSD shall include:

1. Program narratives and module narratives, clearly identifying the processes associated with each, the purpose of the program or module, and interrelationships between the programs and modules;
2. Detailed program logic descriptions and edit logic, including, at a minimum, the sources of all input data, each process, all editing criteria, all decision points and associated criteria, interactions with other programs, and all outputs;
3. Final layouts for all inputs to include, at a minimum, input names and numbers; data element names, numbers, and sources for each input field; and examples of each input;
4. Final layouts for all outputs to include, at a minimum, output names and numbers; data element names, numbers, and sources for each output field; and examples of each output;
5. Final layouts for all files to include, at a minimum, file names and numbers; data element names, numbers, number of occurrences, length and type; record names, numbers, and length; and file maintenance data such as number of records, file space, and so forth; and
6. A detailed comprehensive data element dictionary, including, at a minimum, data element names, numbers, and definitions; valid values with definitions; sources for all identified data elements; and lists from the data element dictionary (DED) in multiple sort formats.

C.7.16.4 Milestones

Milestones for the Design subtask are:

1. District approval of the RSD,
2. District approval of the Detailed Work Plan, and
3. District approval of the DSD.

C.7.17 DEVELOPMENT/TESTING SUBTASK

C.7.17.1 The objectives of the Development/Testing subtask are to:

1. Install and develop enhancement for a certifiable MMIS on the Contractor's hardware;

2. Perform unit, subsystem, and system integration testing to ensure the MMIS will appropriately process and pay all Medicaid claims, make all types of updates, and produce required reports and other outputs;
3. Demonstrate, through integrated testing, that the Contractor is ready to perform all District required functions for the MMIS; and
4. Assure that the District can successfully participate in and audit results of the Acceptance Testing Subtask.

C.7.17.2 Development/Testing Subtask Requirements

The Contractor shall:

1. Establish permanent facilities in District of Columbia for enhancement, development and testing staff.
2. Establish all necessary telecommunications links with the District offices in District, District of Columbia; and
3. Establish the EDP facilities necessary to develop enhancements, test and operate the District MMIS.

C.7.17.3 District Responsibilities

District responsibilities are to:

1. Coordinate communications links with District and the Contractor;
2. Coordinate communications and act as liaison between the new Contractor and the incumbent;
3. Advise the new Contractor of any changes being made to the current District of Columbia MMIS between the contract start date and the first day of the Operations Task;
4. Review and approve on-line systems capabilities;
5. Attend deliverable walk-through to enhance understanding and facilitate the approval process; and
6. Provide input on District policies, and so forth, for provider manuals.

C.7.17.4 Development/Testing Subtask Contractor Responsibilities

Contractor responsibilities are to:

1. Install, modify, and enhance the MMIS software.
2. Maintain a change control process to document discrepancies and their resolution and to manage changes to programs and libraries.
3. Coordinate with the incumbent on questions and problems relating to implementation and testing of the MMIS.
4. Prepare a System Test Plan, as described in Subsection C.7.17.6, and secure District approval prior to beginning the integrated systems test.
5. Perform unit, subsystem, and integrated system tests to ensure that software programs function correctly on Contractor hardware.
6. Prepare the System Test Results deliverable, as described in Subsection C.7.17.7, and provide a walk-through of the subsystem and integrated system test results for District staff.
7. Develop operating procedures, as defined in Subsection C.7.17.8.1, and provide a walk-through for District staff.
8. Prepare user manuals for all subsystems, as defined in Subsection C.7.17.8, and provide a walk-through for District staff.
9. Provide procedures for timely updates to the user manuals and distribution of manual amendments to all manual holders.
10. Prepare provider manuals, as described in Subsection C.7.17.8.2, for all provider types and deliver to the District for approval.
11. Prepare provider bulletins for District approval announcing upcoming changes in the MMIS.
12. Provide orientation for District personnel on Contractor organization, Contractor functional responsibilities, and MMIS operations.

13. Develop a Disaster Recovery Plan, as prescribed in Subsection C.7.17.8.3, and provide a walk-through for District staff.

C.7.17.5 Deliverables

There are seven (7) deliverables defined for the Development/Testing Subtask: System Test Plan, System Test Results, MMIS User Manuals, MMIS Operating Procedures, Provider Manuals, Disaster Recovery Plan, and Revised Detailed System Design. Minimum requirements for each document are presented in the next section.

C.7.17.6 Unit and System Test Plan

Minimum requirements are:

1. A test plan and schedule for each system module and subsystem, as well as for the integrated system; integrated system testing shall include testing those MMIS features which involve more than one (1) subsystem, such as updates to recipient or provider records based on paid claims, interfaces between TPL records and claims payments, processing of claims from input through reporting, and so forth;
2. A description of test situations and expected test results;
3. An organization plan showing Contractor personnel responsible for testing;
4. A discussion of management of the testing effort, including strategies for dealing with delays in the testing effort, back-up plan, back-up personnel, and so forth;
5. Procedures for tracking and correcting deficiencies discovered during testing;
6. A plan for updating documentation based on test results;
7. Procedures for notifying the District of problems discovered in testing, testing progress, adherence to the test schedule, and so forth; and
8. A plan for organizing test results for District review.

C.7.17.7 Unit and System Test Results

Minimum requirements include:

1. All test results, including screen prints, test reports, and test inputs, cross-referenced to the expected test results in the System Test plan;
2. Corrective actions taken and retest documentation for all problems identified in the initial tests and all retests;
3. Integrated system test results which show that the system can perform all integrated functions and can process all claim types from input through reporting; specific claims must be tracked by control number through the system; and

4. A summary of the status of testing, including numbers of problems identified by type of problem, numbers of problems corrected, any significant outstanding issues, the effect of any findings on the implementation schedule; and so forth.

C.7.17.8 MMIS User Manuals

The Contractor shall prepare user manuals for each subsystem described in Section C.6. The user manuals shall be prepared in draft form during the Development/Testing Subtask and in final form during the Acceptance Testing Subtask. During the Operations Task, updates to user manuals must be prepared in final form on all changes, corrections, or enhancements to the system within one week of District technical sign off of the system change. The Contractor shall be responsible for the production and distribution of all user manuals' updates. The following are minimum requirements for MMIS user manuals.

1. The format shall facilitate updating, including use of 8-1/2" x 11" pages in three-ring (3) binder form, pages numbered within each section, and a revision date on each page. Revisions shall be clearly identified.
2. User manuals shall be written and organized so that users not trained in data processing can learn from reading the documentation how to access the on-line screens, read subsystem reports, and perform all other user functions.
3. User manuals shall be written in a procedural, step-by-step format.
4. Instructions for sequential functions shall follow the flow of actual activity.
5. User manuals shall contain a table of contents and an index.
6. Descriptions of error messages for all fields incurring edits shall be presented.
7. Definitions of codes used in various sections of a user manual shall be consistent.
8. Mnemonics used in user instructions shall be identified and shall be consistent with screens, reports, and the data element dictionary.
9. Abbreviations shall be consistent throughout the documentation.
10. Field names for the same fields on different records shall be consistent throughout the documentation.
11. Each user manual shall contain illustrations of screens used in that subsystem, with all data elements on the screens identified by number.
12. Each user manual shall contain a section describing all reports generated within the subsystem, which includes the following:
    a) A narrative description of each report,

b) The purpose of the report;

c) Definition of all fields in reports, including detailed explanations of calculations used to create all data and explanations of all subtotals and totals;

d) Definition of all user-defined, report-specific code descriptions; and

e) A copy of representative pages of each report.

13. Instructions for requesting reports or other outputs shall be presented with examples of input documents and/or screens.

14. All functions and supporting material for file maintenance (for example, coding values for fields) shall be presented together and the files presented as independent sections of the manual.

15. Instructions for file maintenance shall include both descriptions of code values and data element numbers for reference to the data element dictionary.

16. Instructions for making on-line updates shall clearly depict which data and files are being changed.

17. User manuals shall be used as the basis for user training, unless otherwise specified in this document.

C.7.17.8.1 MMIS Operating Procedures

MMIS Operating Procedures define the relationships and responsibilities of Contractor and District personnel for MMIS operations. Minimum requirements are:

1. Operating procedures shall be written in a procedural, step-by-step format;

2. Instructions for sequential functions shall follow the flow of actual activity;

3. Operating procedures shall contain a table of contents;

4. Descriptions of error messages for all fields incurring edits shall be presented;

5. Definitions of codes used in various sections of a manual shall be consistent;

6. Mnemonics used in operating procedures shall be identified and shall be consistent with screens, reports, and the data element dictionary;

7. Abbreviations shall be consistent throughout the documentation;

8. Instructions for making on-line updates shall clearly depict which data and files are being changed; and

9. Operating procedures shall contain any internal reports used for balancing, and so forth, which are not MMIS outputs. All fields in

reports shall be defined, including detailed explanations of calculations used to create all data.

C.7.17.8.2 Provider Manuals

Provider manuals are used to enable the provider community to submit claims in the proper format for adjudication. Each manual shall be specific to a provider type. The minimum requirements are to:

1. Provide general program information;
2. Describe provider enrollment and recertification procedures, general participation requirements, and termination procedures;
3. Describe general medical record content and record retention procedures;
4. Identify third-party resource identification and recovery procedures;
5. Identify methods of verifying recipient eligibility, describe identification cards, describe all relevant recipient information supplied to the provider, and describe why this information is relevant to providing services;
6. Identify covered services and service limitations;
7. Identify reimbursement procedures, including co-payment requirements;
8. Identify any special forms needed and describe how to complete them and submit them (for example, prior authorization, sterilization consent);
9. Provide detailed billing instructions and filing requirements;
10. Describe the process to do adjustments and make refunds;
11. Describe utilization review and control procedures; and
12. Describe how to do provider inquiries.

C.7.17.8.3 Disaster Recovery Plan

The system shall be protected against hardware, software, and human error. The system shall include appropriate checkpoint/restart capabilities, file backup and storage capabilities, hardware and software backup, telecommunications reliability, and disaster recovery. The Disaster Recovery Plan shall be available for review by District or Federal officials on request. The Contractor shall prepare a Disaster Recovery Plan that addresses:

1. Checkpoint/restart capabilities;
2. Real Time data mirroring Transaction back out and recovery plan
3. Retention and storage of back-up files and software;

4. Hardware backup for the servers and data stores processor;
5. Hardware backup for workstation and communications equipment;
6. Alternate source of power:
7. Backup for telecommunications facilities;
8. The continued processing of District of Columbia transactions (claims, eligibility, provider file, and so forth), assuming the loss of the Contractor's primary processing site; this will include interim support for the District on-line component of the MMIS;
9. Back-up procedures and support to accommodate the loss of on-line communication between the Contractor's processing site and District facility in District; these procedures will not only provide for the batch entry of data and provide the Contractor with access to information necessary to adjudicate claims, but will also provide the District with access to the information and processing capabilities necessary to perform its functions;
10. A detailed file back-up plan and procedures, including the off-site storage of crucial transaction and master files; the plan and procedures will include a detailed schedule for backing up critical files and their rotation to an off-site storage facility; the off-site storage facility will also provide for comparable security of the data stored there, including fire, sabotage, and environmental considerations; and
11. The maintenance of current system documentation and source program JCL, and Script libraries at an off-site location.

    Each aspect of the Disaster Recovery plan must be detailed as to both Contractor and user responsibilities and must satisfy all requirements for federal certification. The plan shall be maintained by the Contractor in current form throughout the term of the contract.

C.7.17.8.4 Revised Detailed System Design

The Contractor shall revise the DSD, described in Subsection C.7.1.4.3, to reflect changes identified during the testing process. It must provide updated pages to the District for review and approval.

C.7.17.8.5 Milestones

Milestones for the Development/Testing Subtask are:

1. Facilities and telecommunication links
2. Change control Process
3. District approval of System Test Plan,
4. District approval of System Test Results,

5. District approval of MMIS user manuals,
6. District approval of MMIS operating procedures,
7. District approval of provider manuals,
8. District approval of Disaster Recovery Plan, and
9. District approval of Revised Detailed System Design.

C.7.18 CONVERSION SUBTASK

The Conversion Subtask shall consist of the planning, development, testing, and coordination of all data and file conversions required to support the operation of the new MMIS. The Conversion Subtask shall include the identification of all data elements required to support MMIS processes and those which need to be converted; identification of a source of the data (manual file, automated file, and/or primary data collection); securing the data; development of data conversion requirements, including changes to current provider types, categories of service, diagnosis codes, procedure codes, and so forth; development of conversion software and/or manual procedures; testing of conversion programs and procedures; and preliminary conversion of all files. The Conversion Subtask shall demonstrate, through comprehensive testing of conversion processes, which all data required to support MMIS processing shall be available and accurate. The Conversion Subtask shall be performed concurrently with the Development/Testing Subtask.

This task shall result in a Conversion Plan, Conversion Test Results, and preliminary converted files.

C.7.18.1 Conversion Subtask Requirements

There are no subtask-specific requirements identified.

C.7.18.1.1 District Responsibilities

District responsibilities are to:

1. Assist in identifying other sources of data;
2. Assist in defining code conversions;
3. Clarify, at the Contractor's request, data element definitions, record layouts, and file descriptions; and
4. Provide staff time for walk-through of deliverables.

C.7.18.1.2 Conversion Subtask Contractor Responsibilities

Contractor responsibilities are to:

1. Identify data requirements and source(s) of data for all MMIS files necessary to meet all functional specifications in this RFP;
2. Receive files from District;

3. Obtain data from other sources when approved by District;
4. Prepare a Conversion Plan, and provide a walk-through for District staff;
5. Test conversion programs and procedures, and provide a walk-through of Conversion Test Results for District staff; and
6. Perform preliminary file conversions.

C.7.18.1.3 Deliverables

The deliverables for the Conversion Subtask are the Conversion Plan, Conversion Test Results, and Preliminary File Conversions.

C.7.18.2 Conversion Plan

The Contractor shall provide the following minimum requirements:

1. A detailed plan for conversion of all files, user validation of converted data, and final conversion of files; the plan shall include a detailed conversion schedule and the personnel assigned to the conversion of each file;
2. A description of all files to be converted and whether it will be a manual or an automated conversion, or a combination of both;
3. Data element mappings, including values, of the old system data elements to the new system data elements, and new data elements to old data elements to ensure all data elements are addressed;
4. A discussion of the management of the conversion effort, including strategies for dealing with delays, back-up plan, back-up personnel, and so forth;
5. Procedures for tracking and correcting conversion problems when encountered;
6. Procedures for notifying the District of conversion problems encountered; and
7. Identification of default values, where necessary.

C.7.18.3 Conversion Subtask Conversion Test Results

The Contractor shall provide the following minimum requirements:

1. Interim reporting on each file conversion within twenty-four (24) hours of each scheduled file conversion; this interim report shall include the following for each file conversion:
   a) All test results;

b) Any problems encountered and the impact on the rest of the conversion schedule;

c) Before-and-after versions of each converted file, including default values, formatted for review by non-technical personnel (in certain cases, the District may require only a portion of the file to be formatted for review);

2. A summary of the status of the conversion, including numbers of problems identified by type of problem, numbers of problems corrected, any significant outstanding issues, the effect of any findings on the implementation schedule, and so forth; and

3. Copies of all conversion programs and program listings used during the test.

C.7.18.4 Preliminary Converted Files

The Contractor shall provide the following minimum requirements:

1. Interim reporting on each file conversion within twenty-four (24) hours of each scheduled conversion, to include:

a) Any problems encountered and the impact on the rest of the conversion schedule;

b) Before-and-after versions of each converted file, including default values, formatted for review by non-technical personnel (in certain cases, the District may require only a portion of the file be formatted for review); and

2. Versions of manually and automated converted files available for review on-line, where appropriate.

C.7.18.5 Milestones

Milestones for the Conversion Subtasks are:

1. District approval of Conversion Plan,

2. District approval of Conversion Test Results, and

3. District approval of all preliminary converted files.

C.7.19 ACCEPTANCE TESTING SUBTASK

C.7.19.1 The Acceptance Testing Subtask is designed to demonstrate that the District of Columbia MMIS, as installed by the Contractor, meets District of Columbia specifications and performs all processes correctly. All MMIS subsystems and modules will be tested. Components of the test will require that the Contractor demonstrate readiness to perform all Contractor MMIS functions and contractual requirements, including manual processes. The District will identify the schedule for test cycles and delivery of output.

C.7.19.2 Acceptance testing shall be conducted in a controlled and stable environment. No modifications to the software or files in the acceptance test library shall be made without written prior approval from the District.

C.7.19.3 The District will utilize two (2) types of acceptance testing:

1. Structured data test, and
2. Operational readiness test.

C.7.19.4 The structured data test is designed to test the existence and proper functioning of edits and audits, the accuracy of claims payment and file maintenance, and the format and content of all system outputs, including outputs from reporting functions such as MARS, utilization management, and EPSDT. These tests may utilize all of, or select parts of, the preliminary converted files.

C.7.19.5 The operational readiness test is designed to ensure that the Contractor is ready to process all inputs, price claims correctly, meet all reporting requirements, utilize a properly functioning data communications network, and have a demonstrated back-up capacity. Operational readiness testing shall include a volume test of several days of production capacity claims volumes to demonstrate the MMIS and the Contractor's staffs are prepared for full production. Operational readiness testing shall include a pilot test of actual claims processing in a full operational environment through the check request process.

C.7.19.6 An additional component of the operational readiness test is the demonstration and verification of physical plant security, data security, and fire/disaster prevention and recovery procedures.

C.7.19.7 Requirements

The Contractor shall:

1. Provide a thoroughly tested version of the operational system that meets all District of Columbia requirements and is separate and distinct from its own development and test system;
2. Make the acceptance test system available from 6:30 a.m. to 8:30 p.m., Eastern Time, during the test period; and
3. Provide training to the acceptance testing team, including preparation of input data, using MMIS screens, understanding MMIS processes, and reviewing MMIS outputs.

C.7.19.8 District Responsibilities

District responsibilities are to:

1. Prepare an Acceptance Test Plan,

2. Design acceptance test criteria and procedures,
3. Prepare acceptance test data with the help of the Contractor,
4. Develop an acceptance test schedule,
5. Monitor Contractor support for acceptance testing,
6. Monitor Contractor compliance with the test schedule,
7. Validate results,
8. Inform the Contractor of any problems and or discrepancies,
9. Use the Contractor's change control process to document discrepancies or problems,
10. Monitor Contractor response and resolution of discrepancies or problems,
11. Direct retest after correction of any problems,
12. Document results, and
13. Approve Contractor's operational readiness as a result of acceptance testing.

C.7.19.9 Contractor Responsibilities

Contractor responsibilities are to:

C.7.19.9.1 Ensure that all modifications to the MMIS software or files are thoroughly unit and system tested prior to implementation in the acceptance test.

C.7.19.9.2 Provide access for up to six (6) District representatives at the Contractor's District of Columbia facility during the Acceptance Testing Subtask, if determined necessary by the District.

C.7.19.9.3 Execute acceptance test cycles according to the schedule provided by the District.

C.7.19.9.4 Perform acceptance test activities as defined for regular Operations Task processing.

C.7.19.9.5 Assist the District in implementation of the acceptance test with respect to generation of test transactions, data, and files, as well as analysis of reasons for unanticipated processing results.

C.7.19.9.6 Provide data entry staff and other data processing staff, other than technical or supervisory-level staff, necessary to perform acceptance test activities.

C.7.19.9.7 Provide senior systems analysts and other technical staff necessary to coordinate acceptance test activities and assist the District in the analysis of test results.

C.7.19.9.8 Provide timely responses to discrepancy notices.

C.7.19.9.9 Maintain the acceptance test software and files as directed and approved by the District.

C.7.19.9.10 Correct any problems resulting from incorrect computer program code, incorrect fileconversion, incorrect or inadequate documentation, or from any other failure to meet specifications or performance standards.

C.7.19.9.11 Process, from receipt to final disposition through the check request process, in a fully operational environment, a representative sample of actual or test claims, as designated by the District, as an operational readiness test; the sample shall not exceed a week's volume.

C.7.19.9.12 Prepare the acceptance test resolutions document, including a description of all problems identified; the corrective steps taken; and a summary of outstanding problems by subsystem, status, severity, and type.

C.7.19.9.13 Prepare and deliver to a District approved distribution list of manual users the final version of all user manuals.

C.7.19.9.14 Prepare and deliver to each participating provider and to District Provider Enrollment staff the final version of all provider manuals.

C.7.19.10 Deliverables

There are three (3) deliverables required for the Acceptance Testing subtask: Acceptance Test Resolutions document, final user manuals, and final provider manuals.

C.7.19.11 Acceptance Test Resolutions Document

The Contractor shall provide the following minimum requirements:

1. A summary of the testing process, including number of problems identified and corrected, by type;
2. Description of problems identified and corrective steps taken; and
3. Description of problems outstanding at the end of acceptance testing, the plan for resolution, and the impact on operations.

C.7.19.12 Final MMIS User Manuals

The Contractor shall revise the user manuals, as described in Subsection C.7.17.5, to reflect changes identified during the acceptance test process. The Contractor shall provide updated pages to the District for review and approval.

C.7.19.13 Final Provider Manuals

The Contractor shall finalize the provider billing manuals, as described in Subsection C.7.17.5, to reflect changes identified during the acceptance test process. The Contractor shall provide updated pages to the District for review and approval.

C.7.19.14 Milestones

Milestones for the Acceptance Testing Subtask are:

1. District approval of the Acceptance Test Resolutions document,
2. District approval of final user manuals,
3. District approval of final provider manuals, and
4. District approval of Contractor's operational readiness.

C.7.20 PREPARATION FOR OPERATIONS SUBTASK

During the Implementation Subtask, the Contractor shall load, converted existing data and begin operations of the MMIS. Processing of all claim types shall be activated simultaneously. Date of receipt shall determine whether claims are processed by the new Contractor or the previous Contractor.

The incumbent is responsible for all claims processed through the last payment cycle prior to the Operational Start Date as defined on Paragraph H.37.6 OPERATIONAL START DATE – PERFORMANCE REQUIREMENTS. The new Contractor shall be responsible for all claims not processed or adjudicated by that date. All claims received after the last payment cycle before the current systems shut down are the responsibility of the new Contractor.

It is assumed that the Implementation Subtask will overlap the Development/Testing, Conversion, and Acceptance Testing Subtasks.

C.7.20.1 Implementation Subtask Requirements

There are no subtask-specific requirements identified.

C.7.20.2 District Responsibilities

District responsibilities are to:

1. Coordinate and monitor final conversion activities;
2. Arrange for transfer of all required files to the Contractor;
3. Arrange for transfer of archive files and records;
4. Notify providers of the new MMIS contract and the date from which all claims are to be submitted to the new Contractor;
5. Approve final file conversion;

6. Validate the contents of all edit/audit criteria files and edit disposition files;
7. Provide staff time for initial training of the District management, technical, administrative, and clerical personnel;
8. Provide policy specialists for Contractor provider training sessions to address policy-related questions; and
9. Provide staff time for documentation walk-through.

C.7.20.3 Implementation Subtask Contractor Responsibilities

Contractor responsibilities are to:

C.7.20.3.1 Accept all current files from the District and the incumbent. Files may be magnetic tape, disk, diskette, or paper.

C.7.20.3.2 Accept all claim-related receipts and pended claims on hand from the incumbent for completion of processing.

C.7.20.3.3 Accept and arrange for storage and backup of archive files transferred on computer-readable media. The storage of archive files shall be maintained in an off-site vault that is water and fire resistant, as specified in the Contractor's proposal. The files shall be maintained using archival-quality media that are retrievable by the Contractor.

C.7.20.3.4 Conduct final MMIS file conversion.

C.7.20.3.5 Balance files to the District's and incumbent's control totals.

C.7.20.3.6 Correct any problems identified during final file conversion.

C.7.20.3.7 Plan and conduct initial training to District management, administrative, technical, and clerical personnel. MMIS training must enable District users to prepare inputs, use on-line screens, interpret reports, and fully understand all MMIS processes.

C.7.20.3.8 Plan and conduct Contractor provider training sessions on new billing procedures, policies and MMIS processing with assistance from the District policy specialists.

C.7.20.3.9 Print and distribute all District of Columbia-unique claim forms.

C.7.20.3.10 Accept claims for processing from providers and the District.

C.7.20.3.11 Begin processing all claim types.

C.7.20.3.12 Prepare MMIS Systems Documentation.

C.7.20.3.13 Prepare Start of Operation Plan, and provide a walk-through for District staff.

C.7.20.3.14 Prepare a notice to providers, for District approval, in which transition activities are identified.

C.7.20.3.15 The Contractor shall provide MMIS certification support to include:

1. All State Medicaid Manual Part 11 documentation requirements, reports, and crosswalks necessary to complete certification "folders";
2. Personnel to brief appropriate District staff on certification procedures, system operations, and other information necessary for District staff to make appropriate presentations at the time of certification;
3. A walk-through of the District of Columbia facility and operations, if required by the certification team; and
4. Personnel available to answer questions or provide insight during the certification process.

C.7.20.4 Deliverables

There are five (5) deliverables for the preparation of operations Subtask: MMIS Systems Documentation, MMIS Start of Operations Plan, District Training Plan, Provider Training Plan, and Results of Final File Conversion.

C.7.20.4.1 MMIS System Documentation

C.7.20.4.1.1 The Contractor is responsible for providing to the District complete, accurate, and timely documentation of the MMIS. The Contractor shall provide the MMIS Systems Documentation within thirty (30) days following District acceptance of the MMIS. District acceptance will not be given and the final Systems Documentation cannot be delivered if portions of the MMIS are not functioning properly.

C.7.20.4.1.2 Following the Implementation Subtask, the Contractor shall prepare updates to the MMIS Systems Documentation to incorporate all changes, corrections, or enhancements to the MMIS. Updates to the MMIS Systems Documentation shall be delivered to the District within one week of District technical sign off of the change, unless otherwise agreed to by the District.

C.7.20.4.1.3 Three (3) printed copies and one electronic copy of the final version of the MMIS Systems Documentation must be provided to the District. The Contractor shall be responsible for supplying any copies of the MMIS Systems Documentation required by CMS.

The MMIS Systems Documentation shall:

1. Be available and updated on electronic media (DCD, CD, external hard drive); must be maintainable after Turnover;
2. Be organized in a format which facilitates updating; revisions must be clearly identified;
3. Include system and subsystem narratives which are understandable by non-technical personnel;

4. Contain an overview of the system, including:
   a) A narrative of the entire system,
   b) A description and flow charts showing the flow of major processes in the system,
   c) A description of the operating environment,
   d) The nomenclature used in the overview shall correspond to nomenclature used in subsystem documentation (all subsystems must be referenced, and documentation shall be consistent from the overview to the specific subsystems and between subsystems);
5. Contain the following documentation for each subsystem:
   a) Subsystem name and numeric identification;
   b) Subsystem narrative, including each function and feature of the subsystem;
   c) Subsystem flow charts, identifying each program, input, output, and file;
   d) Job streams and Script within subsystems identifying programs, input and output, controls, job stream flow, JCL, operating procedures, and error and recovery procedures;
   e) Identification and listing of all Contractor internal control reports;
   f) For all forms, screens, tapes, and other inputs: input definitions, including names, descriptions, sources, examples, and content definition;
   g) For all screens, reports, tapes, and other outputs: output definitions, including names, numbers, sources, destinations, examples, and content definition; tape/cartridge specifications, file descriptions, and record layouts shall be included for all data stored on tape or cartridge;
   h) Listings of edits and audits applied to each input item, including detailed edit logic, claim and provider types affected, edit disposition, suspense and override data, and corresponding error messages;

i) Program documentation to include, at a minimum:

1. Program narratives, including process specifications for each, the purpose of each, and the relationships between the programs and modules;
2. A list of input and output files and reports, including retention;
3. File layouts;
4. File names and dispositions;
5. Specifics of all updates and manipulations;
6. Program source listing;
7. Comments in the internal identification division of the listing, identifying changes to the program by date, author, and reason;
8. Comments in the internal procedure division of the listing, identifying each subroutine and each major entrance, exit, and function of the subroutine;

j) Detailed program logic descriptions and edit logic (or decision tables), including, at a minimum, the sources of all input data, each process, all editing criteria, all decision points and associated criteria, interactions and destination links with other programs, and all outputs;

k) Detailed pricing logic for all claims processed by the system;

l) For all files, including intermediate and work files: file descriptions and record layouts, with reference to file names and numbers; data element names, numbers, number of occurrences, length, and type; record names, numbers, and lengths; and file maintenance data, such as number of records, file space, and so forth;

m) Lists, by identifying name, of all files, inputs, and outputs with cross-references to the programs in which they are used;

6. Contain a data element dictionary which will include, for each data element:

a) A unique data element number;

b) A standard data element name;

c) A narrative description of the data element;

d) A list of data names used to describe the data element;

e) A table of values for each data element;

f) The source of each data element;

g) A cross-reference to the corresponding Part 11 of the State Medicaid Manual (SMM);

h) A list of programs using the data element, describing the use of input, internal, or output;

i) List of files containing the data element;

7. Contain operations run documentation with schedules and dependencies; and

8. Support District monitoring activities on an ongoing basis.

C.7.20.4.2 MMIS Start of Operations Plan

The MMIS Start of Operations Plan identifies all the activities, which must be accomplished for a successful implementation, including dates. The Contractor shall provide the following minimum requirements:

1. Identify plans and schedules for designing, ordering, and distributing all required MMIS forms;

2. Identify cutover procedures and dates for submittal of claims on EMC and hard copy;

3. Document resolution of inventory issues (for example, suspense, claims on hand, provider enrollments) and associated dates;

4. Document plans for installation of lines and terminals at the District;

5. Specify methodology for handling adjustments to incumbent-processed claims;

6. Identify procedures and dates for obtaining inputs from outside entities such as HMOs, insurance companies, the enrollment broker, etc.; and

7. Identify the process to accommodate provider updates, recipient data changes, reference changes, and prior authorizations, after final conversion but before implementation.

C.7.20.4.3 District Training Plan

The District Training Plan identifies all the activities leading up to, and including, the training of District user staff, at all levels, in the proper use of the MMIS. The Contractor shall provide the following minimum requirements:

1. Description of training materials;
2. Description of training facilities (for example, use of screens);
3. Training schedule;
4. Plans for remedial training; and
5. Methodology to ensure continued training during the Operations Task for new staff or staff changing positions (for example, use of videotapes).

C.7.20.4.4 Provider Training Plan

The Provider Training plan identifies all the activities leading up to, and including, the training of all provider types in proper billing procedures, understanding of remittance advice, and so forth. The Contractor shall provide the following minimum requirements:

1. Description of training materials,
2. Training schedule for all provider types across the District,
3. Providing experienced training staff throughout the contract period,
4. Locations for training, and
5. Plans for remedial and ongoing training during operations.

C.7.20.4.5 Results of Final File Conversion

The Contractor shall provide the following minimum requirements:

1. Interim reporting on each file conversion within twenty-four (24) hours of each scheduled conversion to include:
   a) Any problems encountered and the impact on the remaining conversion and implementation schedule;
   b) Before-and-after versions of each converted file formatted for review by non-technical personnel, including default values (in certain cases, the District may require only a portion of the file be formatted for review); and
2. Versions of manually and automated converted files available for review on-line, where appropriate.

C.7.20.5 Milestones

Milestones for the Implementation Subtask are:

1. District approval of final file conversions,
2. District approval of District Training Plan,
3. District approval of Provider Training Plan,

4. District approval of MMIS Systems Documentation,
5. District approval of the Implementation Plan, and
6. District approval of the Contractor's notice that the MMIS is fully operational for all claim types.

C.8 OPERATIONS TASK

The Contractor's proposal shall include performance of twenty-six (26) operational subtasks. These subtasks correspond to the functional requirements addressed in Subsection C.6. Each is presented in terms of:

1. District responsibilities,
2. Contractor responsibilities, and
3. Performance Requirements.

In addition to the performance Requirements included in this subsection, specific performance standards are also defined in Subsections H.37 and H.38.

The responsibilities identified for this task include manual, as well as automated, functions. The Contractor must perform all functions necessary to operate a successful, complete, and certifiable District of Columbia MMIS.

The Contractor's responsibilities in this subsection are presented by function.

C.8.1 Recipient Data Maintenance

C.8.2 Recipient Eligibility Help Desk

C.8.3 Provider Data Maintenance

C.8.4 Reference Data Maintenance

C.8.5 Prior Authorization Processing

C.8.6 Claims Control

C.8.7 Claims Entry

C.8.8 Edit/Audit Processing

C.8.9 Claims Pricing

C.8.10 Claims Correction

C.8.11 Claims Operations Management

C.8.12 Financial Processing

C.8.13 TPL Processing

C.8.14 LTC Processing

C.8.15 EPSDT Processing

C.8.16 Quality Control/Assurance

C.8.17 Management and Administrative Reporting

C.8.18 Surveillance and Utilization Review

C.8.19 HCBC Processing

C.8.20 CLIA Support

C.8.21 Drug Rebate Processing

C.8.22 Drug Utilization Review

C.8.1 RECIPIENT DATA MAINTENANCE

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.1.1 District Responsibilities

District responsibilities are to:

1. Determine which individuals are eligible to receive medical assistance benefits;
2. Determine benefit limitations and applicable timeframes;
3. Maintain recipient information, with the exception of recipient lock-in restriction data, on the IMA;
4. Perform on-line updates to recipient lock-in restriction MMIS fields;
5. Accept updates of recipient lock-in restriction data, in an agreed upon format and media, to the IMA from the MMIS;
6. Generate and distribute Medicaid identification cards;
7. Approve content and format of recipient reports and on-line screens; and
8. Assist in the correction of errors and discrepancies resulting from the recipient update process if the Contractor is unable to correct them.

C.8.1.2 Recipient Data Maintenance Contractor Responsibilities

Contractor responsibilities are to:

1. Maintain the MMIS recipient data set(s);
2. Ensure that all existing and new requirements of the District Medicaid Manual, and District and Federal policy are met by the Recipient Data Maintenance function;
3. Apply daily updates to the MMIS recipient file;
4. Perform reconciliation of the MMIS recipient file to the IMA as necessary;

5. Provide on-line update capability for recipient lock-in restriction data fields;
6. Provide staff support to train District personnel on the procedures for submitting on-line recipient lock-in restriction data input to the MMIS;
7. Produce error reports for any on-line transactions that fail any editing;
8. Produce audit trail reports of all recipient lock-in restriction data updates;
9. Notify the District of any discrepancies or errors in IMA, that are evidenced in the MMIS, including unsuccessful update or reconciliation file creation;
10. Research and resolve recipient file discrepancies, seeking District assistance when necessary;
11. Provide on-line inquiry access to all recipient files;
12. Maintain appropriate controls and audit trails to ensure that the most current recipient data is used for the EVS and each claims processing cycle;
13. Perform cross-matching of input from other District agencies to the MMIS recipient file by social security number and generate appropriate reports;
14. Provide the District with all recipient reports according to District specifications; and
15. Support all Recipient Data Maintenance functions, files, and data elements necessary to meet the requirements of this RFP.
16. Provide necessary recipient data to the Managed Care enrollment broker.
17. Receive, edit and update HMO enrollment and disenrollment data form the Managed care Enrollment Broker.

C.8.1.3 Recipient Data Maintenance Performance Requirements

The Contractor shall provide the following Performance Requirement:

1. Daily updates of recipient data accepted from IMA, shall be applied, within a time frame sufficient to transmit the updated data to the EVS Contractor prior to 7:00 am daily.

C.8.2 RECIPIENT ELIGIBILITY HELP DESK

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.2.1 District Responsibilities

District responsibilities are to:

1. Ensure that the most current recipient data is made available to the MMIS.

C.8.2.2 Provision of Eligibility Information Contractor Responsibilities

Contractor responsibilities are to:

1. Provide the most current recipient data available for eligibility, TPL, LTC, and restriction information;
2. Provide appropriate staff levels to support this function;
3. Provide for logging all calls from providers; and
4. Make recommendations on any area in which the Contractor thinks improvements can be made.

C.8.2.3 Provision of Eligibility Information Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Provide sufficient access lines so that District of Columbia Medicaid providers do not encounter busy conditions at least ninety-nine percent (99 percent) of the time;
2. Provide a back-up system to assure that system downtime is limited to a maximum of thirty (30) continuous minutes and no more than four (4) instances per year; and
3. Provide eligibility verification availability 24 hours per day, 7 days a week, except for agreed upon downtime for updates and preventative maintenance.

C.8.3 PROVIDER DATA MAINTENANCE

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.3.1 District Responsibilities

District responsibilities are to:

1. Develop policy governing provider participation in the District of Columbia Medicaid Program;
2. Sign-off on complete enrollment approval packages forwarded by the Contractor;
3. Provide the Contractor with criteria for deactivating/purging providers' records;
4. Provide the Contractor in writing, using file update forms, or on-line, any changes to provider file data which come to the attention of the District;

5. Enter District-approved, provider-specific payment rate updates, including mass or paper updates, into the MMIS on-line;
6. Approve the Contractor's training plan and training materials;
7. Approve the format and content of all reports;
8. Approve or modify all provider issuance's, including manuals, handbooks, bulletins, and notices developed by the Contractor;
9. Monitor the accuracy of telephone information given to providers by Contractor provider relations staff;
10. Approve Contractor-developed EMC billing software and instructions;
11. Determine service restrictions to be placed on individual providers and update provider data on-line;
12. Notify the Contractor of the number, sequence and sort selection of mailing labels to be produced;
13. Perform provider file updates to specific fields finalized during the Design Subtask; and
14. Sign off on enrollment and certification updates for all providers.

C.8.3.2 Provider Data Maintenance Contractor Responsibilities

Contractor responsibilities are to:

1. Establish an organizational unit within the Contractor's District of Columbia MMIS operations site which will be responsible for provider communications, relations, and training in a proactive mode;
2. Operate and maintain the Provider Data Maintenance function, including the maintenance of a provider master data set or master file;
3. Update the provider master file on a daily basis to reflect changes brought to the attention of the Contractor by the District, providers, or from within;
4. Establish methods to edit and verify accuracy of provider file data;
5. Maintain a physical file on all approved and denied providers including source documents received for all provider file update transactions;
6. Receive requests for enrollment and mail all enrollment packets to providers;
7. Process all provider enrollment applications, including reviewing returned packets for completeness and obtaining missing information;
8. Notify providers of acceptance/rejection as a District of Columbia Medicaid provider and send accepted providers a start-up packet containing all the information for participation in and for billing the District for Medicaid services to eligible recipients;

9. Make available to the District on-line inquiry capability for prompt access to the provider files;
10. Contractor Provider Relations staff shall educate and assist providers through on-site visits;
11. Educate providers about the District of Columbia medical assistance program, the claims processing system, and proper billing and prior authorization procedures through workshops, training sessions, presentations at professional association meetings, individual training, as needed, and the production and distribution of provider manuals and bulletins;
12. Target for special training those providers who have been identified as having an abnormal number of claims denied or suspended, as defined by MAA;
13. Maintain and staff toll-free telephone lines for provider inquiries about enrollment, billing, or claim inquiries;
14. Maintain a log of written and telephone inquiries which identifies caller, nature of the inquiry, and outcome;
15. Provide the District with monthly reports on all calls answered and on timeliness of written correspondence;
16. Print at no charge, all claim forms (except UB-92, and HCFA-1500) unique to the District of Columbia Medicaid program, including prior authorization forms;
17. Distribute all claim forms, all consent forms, and maintain inventory control over all forms;
18. Write, obtain District approval of, print, and distribute provider billing manuals, revisions to provider billing manuals, and provider bulletins;
19. Supply all providers with the most current provider manual materials through continual updates, as well as replacement manuals when necessary;
20. Provide copies of provider manuals to MAA and other departments as specified by the District, the number of copies to be determined by the District;
21. Inform providers about electronic billing, automated remittance, and electronic fund transfer options, and work with providers to finalize appropriate formats for the data transfer;
22. Develop and submit to the District for approval a provider training plan annually at the beginning of the contract year and update the plan as necessary;
23. Conduct provider training, including, when necessary, personnel from MAA and other departments;

24. Develop, distribute, and evaluate provider training questionnaires from all training sessions, and provide the District with a summary of the provider responses;
25. Maintain and submit to the District records of all providers (by provider type) who participate in training sessions;
26. Provide training in the use of the Provider system to District personnel initially and on an ongoing basis;
27. Submit all provider reports to the District on a timely basis;
28. Make recommendations on any area in which the Contractor thinks improvements can be made;
29. Support all Provider Data Maintenance functions, files, and data elements necessary to meet the requirements in this RFP;
30. Conduct mass updates of the provider file when directed to do so by the District;
31. Write, with District approval, and distribute, quarterly advisories to providers on current MMIS issues; and
32. Write, with District approval, and distribute, provider satisfaction questionnaires to random sample of twenty-five (25) percent of all providers on a yearly basis.

C.8.3.3 Provider Data Maintenance Performance Requirements

The Contractor shall comply with the following Performance Requirements requested by the District:

1. Mail provider enrollment packets within two (2) days of request;
2. Process complete provider applications within five (5) days of receipt;
3. Staff provider relations phone lines with trained personnel from 8:00 a.m. to 5:00 p.m., Monday through Friday (except District holidays);
4. Maintain a sufficient number of telephone lines so that no more than ten percent (10%) of incoming calls ring busy or are on hold for more than one (1) minute;
5. Answer all calls and telephone contacts on the same day or next business day;
6. Respond to written correspondence with at least an interim answer within fourteen (14) calendar days of receipt and a final response within forty-five (45) calendar days of receipt;
7. Produce and mail 1099's no later than January 31 of each year;
8. Mail claim forms and other billing documents to providers within five (5) days of request for the forms; and

9. Transmit copies of the provider file to the Enrollment Broker, the POS Contractor, and the Data Warehouse and Web Portal no later than 3 working days following the end of each calendar month.

C.8.4 REFERENCE DATA MAINTENANCE

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.4.1 District Responsibilities

District responsibilities are to:

1. Establish specific pricing criteria for all Procedure, Pricing, and Drug files;
2. Identify all service codes (HCPCS, NDC) which are not covered under the District of Columbia medical assistance program;
3. Provide all unique District of Columbia service codes to the Contractor;
4. Specify the benefit limitation and service conflict criteria to be applied through the use of the Edit/Audit Criteria file;
5. Identify the procedures, drugs, and diagnoses which require prior authorization;
6. Define and interpret for the Contractor the detailed policies and payment objectives related to the use of DRG pricing and any other reimbursement methodologies.
7. Initiate updates;
8. Approve all updates on an ongoing basis;
9. Provide the operational and policy parameters used by the Contractor to design or modify edits and audits;
10. Request and approve mass updates (i.e., regular and irregular updates) to files as necessary.
11. Define alternate pricing methodologies to be implemented in the future; and
12. Respond to all inquiries from the Contractor regarding discrepancies in Reference file information.

C.8.4.2 Contractor Responsibilities for Reference Data Maintenance

Contractor responsibilities are to:

1. Operate the Reference Data Maintenance function of the MMIS;

2. Maintain all Reference files and ensure that only the most current information is used in claims processing;
3. Provide the District with on-line inquiry and update capabilities to all Reference files;
4. Provide training to the District in the use of the Reference functions initially and on an ongoing basis;
5. Contract with a drug updating service to update drug prices at least weekly, and provide the District with complete drug catalogs three (3) times per year, and with periodic catalog updates as they are issued by the update service;
6. Perform mass updates to the Reference files as specified by the District;
7. Provide the required reports, listings and/or microform of the Reference files to the District;
8. Support all Reference Data Maintenance functions, files, and data elements necessary to meet the requirements in this RFP;
9. Identify and advise the District of changes to edits and audits to enhance processing and efficiency; and
10. Make recommendations on any area in which the Contractor thinks improvements can be made.

C.8.4.3 Requirements for Reference Data Maintenance Performance

The Contractor shall provide the following Performance Requirements:

1. Correctly apply updates to the Reference files within two (2) working days of receipt of the update request and within the limits specified in the CMS standards; and

2. Provide listings of the Reference files to the District within one (1) week of receipt of the request.

C.8.5 PRIOR AUTHORIZATION PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.5.1 District Responsibilities

District responsibilities are to:

1. Receive and determine approval/denial of prior authorization requests for all District of Columbia Medicaid services that require prior authorization;

2. Enter PA requests, approvals, and so forth onto the MMIS PA system, on-line;
3. Review and approve of all prior authorization error messages and notification letter content;
4. Approve the format of all PA request forms and related material;
5. Specify PA record purge criteria;
6. Provide the Contractor with specific requirements for PA-related reports;
7. Resolve PA disputes at fair hearings; and
8. Determine which services will require prior authorization.

C.8.5.2 Prior Authorization Processing Contractor Responsibilities

Contractor responsibilities are to:

1. Operate the Prior Authorization function of the District of Columbia MMIS;
2. At the District's direction, enter data to the prior authorization function through batch entry or on-line;
3. Purge old PA records according to District-specified criteria;
4. Provide on-line inquiry and access to the PA data set;
5. Produce and mail provider PA notices of approved, denied, or suspended PA requests;
6. Access the PA function during claims processing;
7. Produce all PA reports according to District specifications;
8. Provide training to District staff in the use of the PA screens and reports;
9. Support all Prior Authorization functions, features, and data elements necessary to meet the requirements of this RFP; and
10. Make recommendations on any area in which the Contractor thinks improvements can be made.

C.8.5.3 Prior Authorization Processing Performance Requirements

The performance expectation is to generate PA approval, denial, and suspense notices within twenty-four (24) hours of input or processing.

C.8.6 CLAIMS CONTROL

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.6.1 District Responsibilities

District responsibilities are to:

1. Provide written approval of all accepted internal and external claims processing procedures that are used to adjudicate claims, and to control the audit trails and location within the claims processing system for all claims (for example, medical policy resolution, manual pricing, and so forth);
2. Monitor the Contractor through review of claims processing cycle balancing and control reports; and
3. Establish microform retention and retrieval standards.

C.8.6.2 Claims Control Contractor Responsibilities

Contractor responsibilities are to:

1. Prepare and control all incoming and outgoing District of Columbia medical assistance program mail, to ensure claims and other correspondence are picked up and delivered at/to any site designated by the District, through the most effective and efficient means available;
2. Deliver and pick-up Contractor mail to the District once in the morning and once in the afternoon each work day, and at the request of the District;
3. Establish controls to ensure no mail, claims, tapes, diskettes, cash, or checks are misplaced after receipt by the Contractor;
4. Sort hard-copy claims as approved by the District;
5. Pre-screen hard-copy claims before entering into the system, and return those not meeting certain criteria (for example, no provider number) to providers; log returned claims daily;
6. Assign unique claim control numbers and batches to claims and accompanying documentation;
7. Log tapes and diskettes upon receipt and assign batch number;
8. Batch electronic claims upon receipt and assign a unique control number when loading;
9. Microform hard copy, EMC claims, and accompanying documentation;
10. Establish balancing processes to ensure control within the MMIS processing cycles;
11. Reconcile all claims (hard-copy and EMC) entered into the system to batch processing cycle input and output figures;
12. Produce on-line and hard-copy balancing and control reports according to District specifications; and

13. Make recommendations in any area in which the Contractor feels improvements can be made.

C.8.6.3 Claims Control Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Assign a unique control number to every claim, attachment, and adjustment within twenty-four (24) hours of receipt at the Contractor's site;
2. Return hard-copy claims where the Provider Number is ineligible or missing, the claim form not acceptable to the District, the provider signature is missing, or the claim form is completely illegible within twenty-four (24) hours of receipt;
3. Microform every claim and attachment within twenty-four (24) hours of receipt at the Contractor's site;
4. Retain hard-copy documents and claims until the batch is fully adjudicated; and
5. Retrieve hard-copy claim documentation from microform within twenty-four (24) hours of the request.

C.8.7 CLAIMS ENTRY

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.7.1 District Responsibilities

District responsibilities are to:

1. Define District-unique claim forms and standard claim forms;
2. Provide written approval of the accepted format of all electronic media claims; and
3. Perform periodic review of all claim forms and provide the Contractor with written approval to continue receiving and entering them, to ensure these forms are the most efficient way of collecting data for claims processing.

C.8.7.2 Claims Entry Contractor Responsibilities

Contractor responsibilities are to:

1. Perform data entry of all hard-copy claims;
2. Load electronically submitted claims;

3. Perform presence and format editing on all entered claims, according to District specifications;
4. Perform validity editing on all entered claims using stub files of Provider, Recipient, and Reference data;
5. Distribute provider claim submission software, for all claim forms, to allow electronic claims submission by electronic transfer, diskette, or tape, to all interested providers;
6. Produce all claims entry statistics reports and deliver to the District; and
7. Make recommendations in any area in which the Contractor feels improvements can be made.

C.8.7.3 Claims Entry Performance Requirements

The Contractor shall meet the following Performance Requirements:

1. Enter hard-copy claims within five (5) days of receipt;
2. Maintain data entry error rates below established standards;
3. Load electronically submitted claims within twenty-four (24) hours of receipt by the Contractor; and
4. Perform daily presence, format, and validity editing on entered claims.

C.8.8 EDIT/AUDIT PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.8.1 District Responsibilities

District responsibilities are to:

1. Approve edit and audit criteria;
2. Approve duplicate or suspect-duplicate audit criteria;
3. Approve criteria and procedures for adjudication of "special" claims (for example, bypass edit/audit conditions);
4. Determine prepayment and medical review criteria;
5. Determine the disposition of edits and audits (suspend, deny, report, message only);
6. Provide, on an ongoing basis, written approval of all accepted adjudication processes; and
7. Perform on-line inquiry into edit/audit criteria and disposition files, and update these files as finalized during the Design Task.

C.8.8.2 Edit/Audit Processing Contractor Responsibilities

Contractor responsibilities are to:

1. Propose edit and audit criteria;
2. Propose duplicate or suspect-duplicate audit criteria;
3. Propose criteria and procedures for adjudication of "special" claims (for example, bypass edit/audit conditions);
4. Verify that services performed are consistent with services previously rendered to the recipient and that they comply with District policy and medical criteria;
5. Manually and systematically review any claims that suspend for any of the edits and/or audits as determined by the District for review by Contractor;
6. Adjudicate suspended claims after review by the Contractor or District staff;
7. Process "special" claims, including late billing, recipient retro-eligibility, out-of-District emergency, and any other District-defined situation, in accordance with District instructions;
8. Maintain the edit/audit disposition indicator on an error disposition file in the Reference Data Maintenance function (This file shall also indicate whether a particular edit can be forced or overridden.);
9. Make recommendations on any area in which the Contractor thinks improvements can be made; and
10. Support all Edit/Audit Processing functions, files, and data elements necessary to meet the requirements of this RFP.

C.8.8.3 Edit/Audit Processing Performance Requirements

The Contractor shall meet the following Performance Requirements:

1. Perform at least one (1) edit processing run weekly, and
2. Perform at least one (1) audit processing run weekly.

C.8.9 CLAIMS PRICING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.9.1 District Responsibilities

District responsibilities are to:

1. Provide, on an ongoing basis, written approval of all accepted pricing methodologies; and
2. Perform on-line entry of manual pricing of certain claims.

C.8.9.2 Claims Pricing Contractor Responsibilities

Contractor responsibilities are to:

1. Price all claims in accordance with District of Columbia medical assistance program policy, benefits, and limitations as defined by the District;
2. Process Medicare coinsurance and deductible charges from providers on hard-copy and electronic media;
3. Maintain a method to process for payment any specific claim(s), as directed by the District, on an exception basis and maintain an audit trail; and
4. Make recommendations on any area in which the Contractor thinks improvements can be made.

C.8.9.3 Claims Pricing Performance Requirements

The performance expectation of the Contractor shall be to perform at least one (1) pricing cycle weekly.

C.8.10 CLAIMS CORRECTION

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.10.1 District Responsibilities

District responsibilities are to:

1. Specify error override and force policy and procedures for use by the Contractor in claims correction,
2. Correct claims referred by the Contractor on-line.

C.8.10.2 Claims Correction Contractor Responsibilities

Contractor responsibilities are to:

1. Operate and maintain an on-line claims correction function in the MMIS;
2. Refer claims to the District for correction according to policy;
3. Correct manually and systematically suspended claims from edit and audit processing;
4. Override claim edits and audits in accordance with District guidelines;
5. Monitor the use of override codes during the claims correction process to identify potential abuse, based on District-defined guidelines;
6. Manually review claims which suspend for medical review, and refer some claims to the District medical consultants, as needed; and
7. Make recommendations on any area in which the Contractor thinks improvements can be made.

C.8.10.3 Claims Correction Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Correctly adjudicate all suspended claims, except those suspended for medical review, within thirty (30) days of receipt by the Contractor; and
2. Correctly adjudicate claims suspended for medical review within thirty (30) days from the completion of medical review.

C.8.11 CLAIMS OPERATIONS MANAGEMENT

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.11.1 District Responsibilities

District responsibilities are to:

1. Review and follow up on reported questionable claims from returned EOMBs, and
2. Review all inventory management and other operational claims reports.

C.8.11.2 Claims Operations Management Contractor Responsibilities

Contractor responsibilities are to:

1. Produce and distribute recipient EOMBs;

2. Screen returned EOMBs for discrepancies and produce monthly reports which identify the percentage of claims questioned, the number of claims questioned, and the dollar amount of the claims questioned;
3. Provide on-line inquiry access to active and permanent claims history files and the status of suspended claims;
4. Maintain a claim control and inventory system approved by the District;
5. Provide the District with micro media or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all EMC billings for all transactions processed;
6. Provide training to District staff in the use of the claims processing system, initially and on an ongoing basis;
7. Produce all required claims operations reports and deliver to the District;
8. Provide claims payment data to the District for downloading to District computers;
9. Make recommendations on any area in which the Contractor thinks improvements can be made; and
10. Support all the Claims Operations Management functions, files, and data elements necessary to meet the requirements of this RFP.

C.8.11.3 Claims Operations Management Performance Requirements

The Contractor shall meet the following Performance Requirements:

1. Enter within one (1) day of receipt, District office requests for recipient and provider history printouts;
2. Generate EOMBs on a monthly basis and by noon of the fifth working day after the end of the month; and
3. Produce claims inventory reports after each processing cycle.

C.8.12 FINANCIAL PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.12.1 District Responsibilities

District responsibilities are to:

1. Establish financial processing and adjustment processing policies and procedures,
2. Enter miscellaneous non-claim-specific financial transactions into the MMIS,

3. Define expenditure summarization categories for interface with the statewide accounting system,
4. Review provider 1099 earnings reports and notify Contractor of any discrepancies,
5. Review all other financial reports from Contractor, and
6. Monitor the allocation of District funds to appropriate agencies.

C.8.12.2 Financial Processing Contractor Responsibilities

Contractor responsibilities are to:

1. Produce and mail out remittance advice to providers;
2. Present all messages on the RA in a non-technical language which is understandable to providers;
3. Send check register and warrant file to the District Treasurer at the end of each claims payment cycle;
4. Produce provider 1099 earnings reports annually;
5. Perform adjustments to original and adjusted claims and maintain records of the previous processing;
6. Receive and sort incoming checks from the third-party payers, and providers and direct to the District Treasurer;
7. Maintain a system of security and monitoring for the location and disposition status of each incoming check;
8. Update claim history and on-line financial files with the check number, date of payment, and amount paid after the claims payment cycle;
9. Produce all required Federal and District financial reports;
10. Monitor the status of each account receivable and report monthly to the District in aggregate and/or individual accounts, both on paper and on-line;
11. Follow and monitor compliance with written procedures to meet District and Federal guidelines for collecting outstanding accounts receivable;
12. Provide on-line access to financial information according to District specifications;
13. Make recommendations on any area in which the Contractor thinks improvements can be made;
14. Enter non-claim-specific financial transactions received and processed at the Contractor location; and
15. Support all Financial Processing functions, files, and data elements necessary to meet the requirements of this RFP.

C.8.12.3 Financial Processing Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Perform payment processing at least weekly,
2. Forward all incoming checks to the District Treasurer within twenty-four (24) hours of receipt,
3. Review and adjudicate 100 percent of provider-initiated requests for adjustment within forty-five (45) days of receipt, and
4. Produce and mail out 1099 earnings reports no later than January 31 each year.

C.8.13 THIRD PARTY LIABILITY (TPL) PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.13.1 District Responsibilities

District responsibilities are to:

1. Determine and direct implementation of District of Columbia medical assistance TPL policies;
2. Collect and maintain initial third-party resource information from all sources for all recipients;
3. Collect TPL information from the initial recipient enrollment process on IMA;
4. Provide updates to the MMIS TPL system for newly enrolled recipients;
5. Verify TPL suspect information and follow up on file discrepancies;
6. Collect coverage information from recipients and insurance carriers and maintain it in matrix form, by plan and service, for use by the Contractor in cost avoiding claims;
7. Specify, with CMS approval, which coverage types are to be cost avoided and which are to be paid and recovered, and change this specification when appropriate;
8. Establish coverage type, dollar volumes, and time parameters applicable to thresholds at which accumulated claims are to be recovered;
9. Adjust thresholds and time parameters based on the size of inventory and availability of District staff;
10. Initiate post-payment recovery actions from carriers for claims paid to providers who demonstrated good faith effort to collect from a known third-party resource, but did not receive payment;

11. Investigate, on a post-payment basis, potential casualty/liability situations and determine the need for follow up;
12. Update a TPL case-tracking record for each recipient and carrier for whom recovery is sought, including those for whom retroactive TPL coverage is identified;
13. Determine and initiate follow-up action on aged accounts receivable;
14. Pursue estate benefit recovery;
15. Request claim facsimiles, machine-scannable claims, and copies of microform claims, as needed.

C.8.13.2 TPL Contractor Responsibilities

Contractor responsibilities are to:

1. Operate the TPL processing function of the District of Columbia MMIS;
2. Provide on-line update and inquiry access to TPL carrier file, resource file, case tracking file, and accounts receivable file for District staff;
3. Provide training to District personnel in the use of the TPL system on an ongoing basis;
4. Maintain the TPL system documentation as specified;
5. Deliver all reports created by the TPL function according to District specifications;
6. Produce claim facsimiles or machine-scannable forms to bill carriers for claims paid when retroactive TPL has been identified and mail them out with appropriate cover letter; also produce claim facsimiles or machine-scannable forms at District's request;
7. Notify MAA of changes to recipient TPL coverage identified during claim processing; perform follow up and verification of changes to recipient TPL coverage identified during claims processing;
8. Produce inquiry letters and mail to recipients, providers, and carriers in specified TPL situations;
9. Work out data exchange system with insurance carriers and governmental agencies, and perform data exchanges;
10. Provide copies of microform claims to the District to assist in TPL investigations;
11. Make recommendations for improvements to TPL processing; and
12. Support all TPL functions, files, and data elements necessary to meet the requirements of this RFP.

C.8.13.3 TPL Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Provide copies of microform claims to the District within one (1) working day of request,
2. Provide weekly updates to MAA of TPL information,
3. Update the TPL files with claim information in the same cycle as the payment cycle, and
4. Generate claim facsimiles or machine-scannable forms within one (1) week of request.

C.8.14 LONG TERM CARE (LTC) PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.14.1 District Responsibilities

District responsibilities are to:

1. Maintain recipient-specific data on the MMIS LTC data set,
2. Provide LTC facility rates to the Contractor, and
3. Maintain facility certification.

C.8.14.2 LTC Contractor Responsibilities

Contractor responsibilities are to:

1. Generate remittance advice or HIPAA X12N 835 standard format after a pay cycle to LTC providers,
2. Enter changes to the claims as input to the claims processing system,
3. Produce all LTC reports according to District-specified criteria,
4. Make recommendations on any area in which the Contractor thinks improvements can be made.
5. Maintain an on-line audit trail of all updates to long term care data.

C.8.14.3 LTC Performance Requirements

The Contractor shall support the Minimum Data Set (MDS).

C.8.14.4 The Contractor shall provide and maintain flexibility in coding structures by use of parameter and table oriented driven techniques to enable rapid processing modifications in order to support Medicaid program changes.

C.8.14.5 The Contractor shall generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.8.14.5 The Contractor shall at a minimum provide the following types of reports:

(a) Reports to meet all federal and state reporting requirements; analysis of leave days, by facility type and leave day type;
(b) Discrepancies between patient spend-down amounts on the claim and on the recipient data set;
(c) Tracking of non-bed-hold discharge days;
(d) Re-certifications due within sixty (60) days;
(e) Facility rosters of recipients with mentally impaired/mentally retarded (MI/MR) indicators;
(f) Facility rosters for all facilities that are at or over or nearing state defined capacity thresholds for specified diagnosis codes;
(g) Hospital claims/bed-hold analysis/comparison;
(h) Patients identified with a date of death from claims;
(i) Reports generated by diagnosis;
(j) Non-payment by facility, for lack of prior authorization; and
(k) Paid days of care by month of service, by facility, by program, indicating days of care covered by patient spend-down and other payers.

C.8.14.6 The Contractor shall provide on-line inquiry screens which minimally accommodate the following:

a) Inquiry to current and historical recipient LTC data with access by recipient ID and provider ID; and
b) Inquiry to current and historical provider LTC data with access by provider ID.

C.8.14.7 The Contractor shall provide the on- line screens for the LTC Processing function to support the processing of nursing facility and other LTC facility claims.

C.8.15 EPSDT PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.15.1 District Responsibilities

District responsibilities are to:

1. Inform and periodically re-inform eligible recipients of the availability of EPSDT services and benefits through the eligibility (re)determination process, according to 42 CFR, Part 441;
2. Determine and interpret all policy and administrative decisions regarding EPSDT;

3. Through the District of Columbia Division of Human Services district offices, offer family support services to eligible EPSDT recipients and arrange for those services, when requested, to aid in case-management activities;
4. Maintain EPSDT recipient data on the MMIS;
5. Track the provision of screening or support services for EPSDT eligibles who request them;
6. Perform follow up of recipients who have requested services but for whom there is no indication of service provided;
7. Provide the Contractor with the current periodicity schedule;
8. Monitor program effectiveness using reports produced by the Contractor;
9. Identify all providers of care and specific services to maximize Federal financial participation, and
10. Provide data necessary for the CMS 416 which is not a part of the described MMIS.

C.8.15.2 EPSDT Contractor Responsibilities

Contractor responsibilities are to:

1. Operate the EPSDT function of the MMIS, including the creation of an EPSDT tracking file which includes notification, screening, referral and treatment data for all EPSDT-eligibles;
2. Make available to the District on-line update and inquiry capability for access to the EPSDT files;
3. Generate and distribute periodic re-informing notices for all EPSDT eligibles, as defined and scheduled by the Department of Health;
4. Document services provided and referrals made to meet Federal and District EPSDT reporting requirements and provide the information needed for EPSDT policy decisions;
5. Identify and report abnormalities found during screenings and referred for treatment, from data submitted on claim forms and supplementary forms;
6. Identify and report (from paid claims) clients receiving treatment under the EPSDT program;
7. Produce program management reports containing recipient-level and summary data relating to EPSDT services, referrals, and follow-up treatment;
8. Provide training in the use of the EPSDT Subsystem to Division of Human Services and other District personnel, initially and on an ongoing basis;
9. Maintain EPSDT user manuals for Contractor and District personnel;

10. Make recommendations on any area in which the Contractor thinks improvements can be made; and
11. Support all EPSDT Subsystem functions, files, and data elements necessary to meet the requirements in this RFP.

C.8.15.3 EPSDT Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Apply claims data (for example, screenings, follow-up treatments) to the EPSDT tracking file in the same cycle as the screening and treatment claims are adjudicated to a final status;
2. Generate and mail out EPSDT notifications to newly eligible or reinstated Apply new periodicity schedules to the EPSDT data-set within two (2) working days of receipt from the District; and
3. Perform initial EPSDT notification informing within sixty (60) days of eligibility determination.

C.8.16 QUALITY CONTROL/ASSURANCE

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.16.1 District Responsibilities

The District responsibility is to use the integrated test facility (ITF) to monitor activities by setting up test providers and recipients, submitting test inputs, modifying test reference files, and reviewing test outputs.

C.8.16.2 Quality Control/Assurance Contractor Responsibilities

Contractor responsibilities are to:

1. Monitor MMIS operations against the internal controls and correct deficiencies when they are identified through internal control reviews;
2. Operate and maintain an integrated test facility (ITF), which simulates a production environment and allows for unique identification of test claims, test providers, and test recipients to maintain the integrity of the test data;
3. Provide the District with on-line access to the ITF and all test files to submit test data independently without notice to the Contractor;
4. Report on the impact of test cycles and compare those results to the actual processing results;
5. Keep all test outputs separate from routine MMIS outputs and clearly label all outputs as test outputs;

6. Support all ITF functions, files, and data elements necessary to meet the requirements in this RFP;
7. Make recommendations for improvements when possible; and
8. Produce and review all control reports generated for each update and processing cycle.

C.8.16.3 Quality Control/Assurance Performance Requirements

The Contractor shall provide Performance Requirements to test outputs within the time periods determined by the District.

C.8.16.4 SECURITY MANAGEMENT

The Contractor shall provide the function for the provision of automated support needed to manage the security of the MMIS. The state will maintain the security tables that control access to the MMIS, data, and system software, by user.

C.8.16.4.1 Inputs

The MMIS Security Management function shall accept the following inputs:

(a) Additions and changes of user security profiles, and
(b) Log-ons to the MMIS requesting access.

C.8.16.4.2 Processing

The Contractor shall provide MMIS Security Management Processing function with the following processing capabilities:

C.8.16.4.3 Provide and maintain flexibility in coding structures by use of parameter and table oriented design techniques to enable rapid processing modifications in order to support DC Medicaid health care program changes.

C.8.16.4.4 Provide for context-sensitive help on screens for easy, "point and click" access to valid values and code definitions by screen field.

C.8.16.4.5 Provide for a single unique log-ons for each user of the MMIS.

C.8.16.4.6 Provide for user passwords that will expire on a staggered schedule and that can be changed at any time by the appropriate District or Contractor management personnel.

C.8.16.4.7 Provide for restriction of application and/or function within application (inquiry only, update capability) to specific log-ons.

C.8.16.4.8 Provide for on- line audit trails of all updates of security management data.

C.8.16.4.9 Provide for access control to all data and to the applications software employing a security system to restrict access to varying hierarchical levels of data and function.

C.8.16.4.10 Provide the capability to establish multilevel security settings by either group(s) or individual(s).

C.8.16.4.11 Provide for independent security access to any standalone component of the MMIS that is not part of the "core" MMIS.

C.8.16.4.12 Provide on- line screens for the maintenance of MMIS security management data, minimally providing for the maintenance of unique user profiles and their unique log-on, password, and security profile.

C.8.16.4.13 Provide for the same hierarchical password protection, as well as a system inherent mechanism for recording any change to a software module or subsystem.

C.8.16.4.14 Maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times.

C.8.16.4.15 Edit all data for presence, format, and consistency with other data in the update transaction and on all security management processing and data related tables.

C.8.16.4.16 Maintain password control, in varying levels of security, of staff making changes to security management data.

C.8.16.4.17 Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.8.16.4.18 **Outputs**

The MMIS Security Management function shall provide the following outputs and support the following information needs:

C.8.16.4.19 All data shall be available for retrieval through the DSS/DW function.

C.8.16.4.20 All reports shall be made available in data format for export and import purposes and through multiple media including paper, CD-ROM, electronic file, imaging, microform, diskette, and tape cartridge.

C.8.16.4.21 Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.8.16.4.22 The following types of reports shall minimally be available:

(a) Audit trails of system log-ons, and

(b) Lists of users and their security profile.

C.8.16.4.23 **Interfaces**

There are no external interfaces identified for the Security Management Function.

C.8.16.5 CUSTOMER SERVICE

One of District' s main objectives is to provide quality customer service to the recipients, providers of services, and its stakeholders. The Contractor shall include the tools to facilitate providing customer service as expeditiously and professionally as possible for both MAA customer service staff and MMIS Contractor staff fielding claims status inquiries.

C.8.16.5 Inputs

The following are inputs to the MMIS Customer Service function:

a) telephone calls from recipients, providers, county offices, representatives/legislators, advocacy groups, out of state entities s, potential providers, health plans, and Medicare inquiring on information including:

1. Why claims have not been paid;
2. Claim status;
3. Denial reason;
4. Services clients are entitled to based on their eligibility;
5. Policy for claims;
6. Recipient eligibility and eligibility-related information about the recipient, including TPL;
7. DOH medical assistance policy;
8. How to:
   - Submit claims, and claim completion,
   - Utilize the Eligibility Verification and Provider Inquiry System,
   - Utilize POS/PRO-DUR, and
   - Use of other components of the MMIS;
9. How to seek prior authorization; and
10. Other questions and requests pertaining to DC Medicaid programs, policies and operational procedures.

C.8.16.5.1 Processing

The MMIS Customer Service function shall include the following capabilities:

C.8.16.5.2 Provide for context-sensitive help on screens for easy, "point and click" access to valid values and code definitions by screen field.

C.8.16.5.3 Provide and maintain flexibility in coding structures by use of parameter and table oriented design techniques to enable rapid processing modifications in order to support DC Medicaid health care program changes.

C.8.16.5.4 Provide an automatic phone call attendant capability that provides a hierarchical menu driven capability for directing calls to appropriate MMIS Contractor staff or MAA staff - This system shall allow the caller to indicate the type of caller they are (for example, provider, recipient, county office, others) and then select the nature of the call which they are making (for example, claims status inquiry, questions regarding fee- for-service, managed care, eligibility status, edit disposition, ID card, referrals, authorizations, others). Based upon this information the phone call shall be distributed to the appropriate state or Contractor staff.

C.8.16.5.5 Maintain an automated call tracking capability for all calls received. The system should track information such as, time and date of call, identifying information on caller (provider, recipient, and others), call type, call category, inquiry description, customer service clerk ID for each call, and response description.

C.8.16.5.6 Provide for unique identification of call records.

C.8.16.5.7 Provide for on- line display, inquiry, and updating of call records with access by call type, recipient number, provider number, inquirers name, recipient name, provider name, or a combination of these data elements.

C.8.16.5.8 Provide for the automated population of call screens, based on what recipient and/or provider the call is in reference to, with relevant recipient and provider information including:

(a) Eligibility information (including dates) including:
(b) Date of birth,
(c) Social security number,
(d) Recipient ID,
(e) Third party liability information,
(f) Long-term care information,
(g) Responsible party information, and
(h) Spend down information,
(i) Enrollment status and dates,
(j) Demographics including:
    1. name,
    2. address,
    3. telephone number,
    4. county of residence, and
(k) Managed care information including MCO name and telephone number, and enrollment information.

C.8.16.5.9 The Contractor shall provide the capability to easily navigate (at a point and click) from call logging screens to other data relevant to providers and recipients within the MMIS including claims history and eligibility information.

C.8.16.5.10 The Contractor shall provide the capability to maintain free-form notes to each call record.

C.8.16.5.11 The Contractor shall provide the capability to refer or forward call records to other MAA units for resolution.

C.8.16.5.12 The Contractor shall provide the capability to update and maintain call records with basic call identifying information. This information shall include the caller, who the call is about, customer service clerk ID, date of call, date of referral, unit being referred to, nature of call, details of call, length of call, call resolution clerk ID, resolution date, resolution, and call status, with accumulation of daily totals per each customer service clerk ID.

C.8.16.5.13 The Contractor shall provide for automated inquiry and response for claims status information, using up to twelve (12) months of history, via a voice response component of the Eligibility Verification and Provider Inquiry System and for the request and receipt of, remittance advices and paid claims history, and claim status information available through the Internet.

C.8.16.5.14 The Contractor shall provide for on-line updateable templates of letters to providers, recipients, and others, providing call resolution information.

C.8.16.5.15 The Contractor shall **a**utomatically generate letters to providers, recipients, and others.

C.8.16.5.16 The Contractor shall provide the ability to automatically fax-back to callers with attachments containing requested information such as claims histories, copies of pertinent policy or rules, and MAA provider letters.

C.8.16.5.17 The Contractor shall Maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times.

C.8.16.5.18 The Contractor shall Maintain an on-line audit trail of all updates to customer service data.

C.8.16.5.19 The Contractor shall **e**dit all data for presence, format, and consistency with other data in the update transaction and on all customer service processing and data related tables.

C.8.16.5.20 The Contractor shall **m**aintain password control, in varying levels of security, of staff making changes to customer service data.

C.8.16.5.21 The Contractor shall provide on- line, updateable letter templates for recipients, providers or submitter/biller letters with the ability to add free form text specific to a recipient, provider or submitter/biller.

C.8.16.5.22 The Contractor shall provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.8.16.5.23 Outputs

The MMIS Customer Service shall provide the following outputs and support the following information needs:

C.8.16.5.24 All data shall be available for retrieval through the DSS/DW function.

C.8.16.5.25 The Contractor shall provide **a**ll reports in data format for export and import purposes and through multiple media including paper, CD-ROM, electronic file, imaging, microform, diskette, and tape cartridge.

C.8.16.5.26 The Contractor shall **g**enerate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.8.16.5.27 The following types of reports shall be minimally be available:

(a) Weekly Activity Reports (ACD Traffic), to include:
incoming calls received,
incoming calls answered,
after hours calls,
cumulative calls answered,
total calls abandoned,
abandoned/lost rate percent,
agent hours logged on,
average calls (inbound) per FTE,
average calls (inbound) per hour,
average wait time/minute (ASA),
average hold time in queue,
average talk time (minutes),
agent active/available percent,
total outbound calls, and
routed to non ACD number,

(c) Weekly Calls Abandoned, the number of calls abandoned sorted by number of seconds of the length of the call;
(d) Weekly Answered Call Profile Report, the number of calls answered sorted by number of seconds of the length of the call;
(e) Top 25 Users Weekly;

(f) Customer Service Call Center To-Date Statistics:
Monthly Reports, displaying weekly totals of caller types including provider, recipients, county offices, others, regarding specific categories including fee-for service, managed care,
Customer Service Provider Calls/Recipient Calls by Hour (Busy Hour Report) Monthly to include calls received during business hours including average calls by day of week report, and
Quarterly – Activity Reports;
(g) Letters to recipients and providers;
(h) Call referrals to other units; and
(i) Fax-back of information to recipients and providers.

C.8.16.5.28 Interfaces

The MMIS Customer Service function shall accommodate an external interface with the District's telephone system.

C.8.16.6 INTERNET

The Contractor shall provide the capability and infrastructure to facilitate the authorized access to information through the use of the Internet. The Contractor developed web site shall have the "look and feel" of the current MAA site including MAA page layout, menu and formatting standards, and shall meet draft MAA security, confidentiality and privacy requirements and HIPAA and other federal security, confidentiality and privacy requirements.

C.8.16.6.1 Inputs

The Contractor shall provide the capability via the secured MMIS Internet web site to enter:

(a) Claims data, including status, payment, and history;
(b) Prior authorization data;
(c) Reference data;
(d) Recipient data;
(e) Managed care recipient rosters;
(f) Managed care recipient assignments form MCOs;
(g) Provider information including training programs and publications;
(h) Remittance advices for fee-for-service, capitation and encounter processing activity;
(i) Eligibility verifications; and
(j) Medical assistance administrative data.

C.8.16.6.2 Processing

The Internet function shall include the following capabilities:

C.8.16.6.3 The MMIS Contractor shall provide a secure web site for access by authorized providers and MAA approved entities.

C.8.16.6.4 The secure web site shall meet the MAA "look and feel" specifications following the DC website requirements.

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C.8.16.6.5 The secure web site shall include:

(a) instructions on how to use the secure site,
(b) a site map, and
(c) contact information.

C.8.16.6.6 The secure web site shall comply with all HIPAA transactions and provide for claims-related Internet functionality including:

(a) Electronic claims and encounter data submission,
(b) Claims and encounter data capture with limited edits,
(c) Inquiry to edit disposition information,
(d) Claims processing status,
(e) Remittance advice for active providers for the last ten (10) cycles,
(f) Prior authorization requests and responses (approval/denials/requests for additional information),
(g) Help capability.

C.8.16.6.7 The secure web site must provide for recipient-related Internet functionality including completing and submitting, but not processing, short- form, two page, recipient applications for eligibility.

C.8.16.6.8 The secure web site shall provide for recipient eligibility verification-related Internet functionality including:

(a) Interactive provider eligibility verification inquiry and response, and
(b) Receipt of provider requests for, and distribution of, historical listings of eligibility verification inquiries made and the responses given.

C.8.16.6.9 The Contractor shall provide links from its MMIS web site to other state and federal web sites, including:

(a) The MAA site,
(b) District of Columbia Home Page, and
(c) The CMS site.

C.8.16.6.10 The secure web site shall provide for Provider-related Internet functionality including:

(a) Provider publications and billing manuals,

(b) Managed Care interfaces for viewing and updating recipient rosters,
(c) Claims history distribution to requesting providers,
(d) Managed care interfaces with MCO submittal of recipient PCP selections/assignments, and
(e) Provider training.

C.8.16.6.11 The Contractor shall provide and maintain flexibility in coding structures by use of parameter and table oriented design techniques to enable rapid processing modifications in order to support DC Medicaid health care program changes.

C.8.16.6.12 The Contractor shall maintain access to data through user friendly systems navigation technology and a graphical user interface that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times.

C.8.16.6.13 The Contractor shall provide for context-sensitive help on screens for easy, "point and click" access to valid values and code definitions by screen field.

C.8.16.6.14 The Contractor shall maintain an on- line audit trail of all updates to Internet data.

C.8.16.6.15 The Contractor shall edit all data for presence, format, and consistency with other data in the update transaction and on all Internet processing and data related tables.

C.8.16.6.16 Maintain password control, in varying levels of security, of staff making changes to managed care data.

C.8.16.6.17 The Contractor shall provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

C.8.16.6.18 Outputs

The MMIS Internet shall provide the following outputs and support the following information needs:

C.8.16.6.19 All data shall be available for retrieval through the DSS/DW function.

C.8.16.6.20 All reports shall be made available in data format for export and import purposes and through multiple media including paper, CD-ROM, electronic file, imaging, microform, diskette, and tape cartridge.

C.8.16.6.21 Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

C.8.16.6.22 Claims data, including status, payment, and history.

C.8.16.6.23 Prior authorization data.

C.8.16.6.24 Managed care recipient rosters.

C.8.16.6.25 Provider training and publication information.

C.8.16.6.26 Recipient data.

C.8.16.6.27 Remittance advices for fee- for-service, capitation and encounter claims processing activity.

C.8.16.6.28 Medical assistance administrative data.

C.8.16.6.29 Interfaces

The interfaces to the Internet site include:

(a) MMIS tables and data;
(b) State approved hyperlinks;
(c) Providers; and
(d) MAA and other district staff.

C.8.17 MANAGEMENT AND ADMINISTRATIVE REPORTING (MARS)

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.17.1 District Responsibilities

District responsibilities are to:

1. Define required MARS reports, including the content, format, frequency, and media for the reports;
2. Initiate or approve report changes, additions, deletions, and other maintenance to the Management Reporting function;
3. Approve in writing the content, format, and documentation of all new reports;
4. Define District and Federal categories of service, eligibility categories, provider type and specialty codes, district codes, town codes, accounting codes, funding source codes, and other codes necessary for producing the reports;
5. Monitor production of all reports and review reports produced to assure compliance with RFP and contract requirements;
6. Review balancing reports to ensure internal and external report integrity;
7. Respond to all requests from other parties for data on the medical assistance programs that require the use of MARS reports;

8. Provide the Contractor with information necessary to complete the administrative portion of the CMS-64 Quarterly Statement of Expenditures; and
9. Provide the Contractor with any data required for complete financial reporting which is not generated or maintained by the systems operated by the Contractor.

C.8.17.2 MARS Contract Responsibilities

Contractor responsibilities are to:

1. Operate and maintain the Management and Administrative Reporting function of the MMIS according to Federal MMIS certification requirements, the CMS District Medicaid Manuals, CMS Systems Performance Review, and all District requirements;
2. Produce all MARS reports and other outputs within the time frames and according to the format, input parameters, content, frequency, media, and number of copies specified by the District;
3. Generate all reports to be sent to CMS in the media required;
4. Deliver reports on a variety of media, including hard copy, micro media, tape, or diskette as specified by MAA;
5. Modify the reports to meet the changing information needs of the District of Columbia Medical Assistance program and ensure compliance with changes in Federal, District, or Department regulation, procedures, or policies;
6. Provide and maintain complete documentation for MARS which defines the purpose of each report, specifically describes the definition of each reporting category, and data elements contained therein, their sources, the frequency of the report, and the report distribution and media; include a master matrix of data elements indicating which reports contain that data element;
7. Balance MARS report data to comparable data from other MARS reports to ensure internal validity and to non-MARS reports to ensure external validity, and provide an audit trail; deliver the balancing report to the District with each MARS production run;
8. Provide the District with a user manual for all reports to ensure understanding of the report content, and include instructions for balancing the reports;
9. Respond to District requests for information concerning the reports;
10. Produce, submit, and correct, if necessary, MEDSTAT tapes for CMS, according to CMS time frames;
11. Provide training in the use of the MARS function to District personnel on an ongoing basis;

12. Ensure the accuracy of all reports before delivery to the District;
13. Provide uniform cut-off points for every report to ensure the consistency of all reports;
14. Make recommendations on any area in which the Contractor thinks improvements can be made;
15. Support all reporting functions, files, and data elements necessary to meet the requirements in this RFP; and
16. Deliver to the District a hard copy and diskette copy of monthly CMS 2082 reports.

C.8.17.3 MARS Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Process MARS file updates at least monthly,
2. Respond to District requests for information about the reports with a resolution no later than three (3) workdays after the request, and
3. Save final output files for at least six (6) months.

C.8.18 SURVEILLANCE AND UTILIZATION REVIEW (SUR)

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.18.1 District Responsibilities

District responsibilities are to:

1. Establish policy and make or delegate all administrative decisions concerning the operation of, and any changes to, the SUR reporting function;
2. Approve or request modification of the Contractor's SUR reporting system training plan;
3. Approve or request modification of the SUR reporting User Manual;
4. Update the SUR management control file and the parameters for the reports;
5. Define criteria for extraction of claim data for utilization reports;
6. Analyze reports and follow through with manual reviews and field audits, when necessary;
7. Perform detailed analysis of recipient and provider profiles referred by Contractor staff;
8. Investigate fraud-related cases and propose corrective action;

9. Determine modification of reports to meet District and Federal requirements, as necessary;
10. Monitor the Contractor's operation of the SUR reporting system;
11. Determine the appropriate action for questionable provider practices and recipient utilization referred by the Contractor, and initiate an update to the provider and/or recipient data sets for those providers and recipients placed on lock-in, prepayment review, or other restrictions;
12. Refer recipients to appropriate utilization programs for restriction and/or monitoring, within the constraints of current legislation;
13. Monitor restricted recipients and providers, and determine when to remove restrictions;
14. Monitor managed care recipients; and
15. Submit claim detail requests and requests for provider and recipient profiles.

C.8.18.2 SUR Contractor Responsibilities

Contractor responsibilities are to:

1. Maintain and operate a SUR system to meet the most recent Federal requirements;
2. Perform initial analysis of SUR exception profiles;
3. Identify recipients for lock-in, and make recommendations to the District;
4. Identify providers to be placed on review, and make recommendations to the District;
5. Train District staff on the use of the SUR reporting system, initially and on an ongoing basis;
6. Produce and maintain a SUR reporting User Manual on the use and purpose of this function;
7. Develop a weighting and ranking method, subject to Department approval, to set priorities for reviewing utilization review exceptions;
8. Receive weekly claim detail requests from the District;
9. Produce claim detail reports, and provider and recipient profiles, as requested by the District;
10. Furnish routine SUR management reports to the District in hard copy and micro media;
11. Advise the District of any changes needed in the SUR function to correspond to changes made to other MMIS functions;
12. Make recommendations on any area where the Contractor thinks improvements can be made;

13. Support all SUR functions, files, and data elements necessary to meet the requirements in this RFP; and
14. Propose changes to report contents based on reviews.

C.8.18.3 SUR Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Apply all file updates within the time constraints specified in the CMS,
2. Save final output files for at least six (6) months,
3. Deliver claim detail reports within two (2) work days of receipt of the request, and
4. Meet CMS certification review requirements for SURS.

C.8.19 HOME AND COMMUNITY BASED CARE (HCBC) PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.19.1 District Responsibilities

District responsibilities are to:

1. Determine recipient eligibility for HCBC, and transmit special eligibility authorizations to IMA;
2. Determine policy and prices associated with special HCBC services;
3. Transmit on-line updates to MMIS reference date to support HCBC processing; and
4. Receive and review MMIS generated reports related to HCBC services, providers or recipients.

C.8.19.2 HCBC Contractor Responsibilities

Contractor responsibilities are to:

1. Implement all RFP required functions related to HCBC processing;
2. Produce all RFP required reports and retrieve all data necessary to support the HCBC processing function;
3. Analyze and support the requirements related to the Developmentally Disabled and Mentally Ill waiver programs, including downloading of claims data to District PC networks, and report generation; and
4. Provide technical assistance, as needed, to MAA users, including development of report specifications, research on problems, review of

production output, and analysis and manipulation of downloaded claim data.

C.8.19.3 HCBC Performance Requirements

The Contractor shall provide claims data to MAA within three (3) days of the last payment cycle in a month.

C.8.20 CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) SUPPORT

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.20.1 District Responsibilities

District responsibilities are to:

1. Review and interpret federal CLIA requirements, and inform the Contractor of steps that must be taken to implement requirements through the MMIS; and
2. Transmit provider and reference data needed to implement CLIA to the Contractor on-line or in batch as appropriate.

C.8.20.2 CLIA Contractor Responsibilities

Contractor responsibilities are to:

1. Implement all MMIS supported, CLIA functional requirements as requested by the District; and
2. Receive and maintain provider and reference data used to support MMIS processing of laboratory claims in accordance with CLIA requirements.

C.8.20.3 CLIA Performance Requirements

The Contractor shall apply all providers and reference file updates within the time constraints specified in the CMS CLIA guidelines.

C.8.21 DRUG REBATE PROCESSING

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.21.1 District Responsibilities

District responsibilities are to:

1. Interface with CMS on policy and procedural issues related to drug rebate processing,
2. Review all drug rebate reports from Contractor, and
3. Monitor the rebate collection and dispute resolution processes.

C.8.21.2 Drug Rebate Processing Contractor Responsibilities

Contractor responsibilities are to:

1. Update manufacturer information,
2. Produce invoices,
3. Maintain accounts receivable system,
4. Implement and staff a dispute resolution process, and
5. Employ at least one pharmacist consultant to support activities related to drug rebate processing.

C.8.21.3 Drug Rebate Processing Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Comply with federal timeliness requirements in producing invoices, and
2. Provide the District with at least weekly or on request reports related to the status of rebate accounts receivable.

C.8.22 DRUG UTILIZATION REVIEW (DUR)

The following subsections describe District responsibilities, Contractor responsibilities, and performance Requirements for this function.

C.8.22.1 District Responsibilities

District responsibilities are to:

1. Determine composition of, establish, and arrange for appointments to the DUR Board;
2. Review and approve or modify Contractor developed review standards and criteria for disease categories and therapeutic classes which will flag individual recipients and providers for exceptional drug utilization patterns; and
3. Follow up with recipients and providers who have been found by the Contractor to exhibit verified drug use or prescribing aberrance’ s.

C.8.22.2 DUR Contractor Responsibilities

Contractor responsibilities are to:

1. Operate retrospective components of the Drug Utilization Review function of the MMIS;
2. Develop draft review standards and criteria which can be used to flag individual recipients and providers for exceptional drug utilization patterns;
3. Present draft standards and criteria to the DUR Board for review and make any modifications requested by the Board;
4. Provide training to District, Contractor staff, or providers on application of DUR methodologies;
5. Perform first level review of all problems identified by retrospective DUR, referring to the District only those cases where aberrance' s have been substantiated;
6. Provide the District with all required reports from the DUR system;
7. Provide all other required DUR outputs; and
8. Make recommendations on any area in which the Contractor thinks improvements can be made.

C.8.22.3 DUR Performance Requirements

The Contractor shall provide the following Performance Requirements:

1. Deliver all DUR reports within the time frame specified by the District, and
2. Review literature on DUR and report to the DUR Board and the District on a regular basis.

C.9 MODIFICATION TASK

The Contractor shall be responsible for maintaining and modifying the District of Columbia MMIS throughout the term of the contract. This section of the Statement of Work describes how future changes to the system will be categorized, the minimum staffing requirements, the milestones that must be met within task activities, and how District and Contractor responsibilities are split.

In addition, the Contractor shall update and maintain all MMIS functions according to the CMS District Medicaid Manual; all Federal mandates; and all District requirements, statutes, and regulations.

C.9.1 OVERVIEW

The Contractor shall perform software maintenance and modifications for the component parts of the MMIS after its implementation, as requested by the District. Some major

program initiatives may require a prior-approved Advance Planning Document when additional resources are required. It is the District's expectation that all maintenance and most modifications will be met at no additional cost for machine time, person time, and documentation support.

Ongoing changes, corrections, or enhancements to the system will be characterized as either maintenance-related or as a modification effort. Maintenance may result from a determination by the District or by the Contractor that a deficiency exists within the operational MMIS, including deficiencies found after implementation of modifications incorporated into the operational MMIS, or that continued efficiency can be maintained or achieved through the proposed activity. In general, the various types of maintenance support can include:

1. Activities necessary to provide for continuous effective and efficient operation of the system to keep it ready and fit to perform at the standard and condition for which it was approved;
2. Activities necessary to modify the system to meet the requirements detailed in this RFP;
3. Activities necessary to ensure that all data, files, and programs are current and that errors are reduced;
4. Activities necessary to meet CMS certification requirements which exist at the time of contract award and ongoing standards changes;
5. File maintenance activities for updates to all files;
6. Changes to JCL or system parameters concerning the frequency, number, and media of reports;
7. Changes to edit disposition parameters for established edit or audit criteria; and
8. Addition of new values and changes to existing system tables and conversion of prior records, as necessary.

Software modifications may result when the District or the Contractor determines that an additional requirement needs to be met or that a modification to existing file structures or current processing is needed. Examples of modification tasks include:

1. Implementation of capabilities not specified in this RFP or agreed to during design and development;
2. Implementation of edits and audits not defined in the operational system accepted by the District;
3. Changes to established report, screen, or tape formats, such as sort sequence, new data elements, or report items; and
4. Acceptance of a new input form.

System modification activities will be managed by the Distict through a Customer Service Request (CSR) process.

C.9.2 SYSTEM MODIFICATION TEAM STAFFING REQUIREMENTS

At a minimum, full-time support for system modifications shall be provided on-site in the District of Columbia by:

1. A Modification Task Manager,
2. Two (2) systems analysts, and
3. Areporting specialist.

The minimum qualifications for the Modification Task Manager are specified in Subsection C.4.4. The two (2) systems analysts shall each have a minimum of two (2) years of experience in MMIS development or ongoing maintenance and modification. The reporting specialist must have a minimum of two (2) years of experience in a combination of ad-hoc, data base, and report writer software, such as Easytrieve, Dyl-280, and DB2; personal computer-based software, such as DBASE IV, Quattro Pro, and Lotus; and statistical analysis packages, such as SPSS and SAS.

The Modification Task Manager shall serve as the primary liaison between the Modification Team resources and the District for all system changes. The reporting specialist must be responsible for supporting the needs of the District with respect to the Ad Hoc reporting function, but need not be dedicated full time to this assignment. The reporting specialist shall be resident at the District's facility in District, District of Columbia.

The Contractor shall also provide the equivalent of two (2) full-time programmer/analysts on an ongoing basis for modification support. This support can be provided off-site, and, if so, the District will have access to four thousand (4,000) hours of available time each contract year. The District determines when these modification hours are to be used and must approve all hours. See Subsection H.25 for additional requirements.

The Contractor shall provide sufficient staff to perform all normal systems maintenance responsibilities. These individuals are separate and distinct from those defined above for modification support. They may be located on-site or off-site.

C.9.3 MODIFICATION TASK ACTIVITIES AND MILESTONES

System modification activities will be required through a written customer service request (CSR) completed by the District. The Contractor must respond, in writing, to District-initiated change requests within five (5) working days of receipt. The response shall consist of an acknowledgement of the request, its priority, and a preliminary assessment of the effort required to complete the change. Within fifteen (15) working days of receipt of a modification request, the modifications staff shall submit a Requirements Analysis and Specifications document. This document shall identify problem definition, problem solution, and the level of effort required to code, test, implement, and update documentation related to the requested change(s). The District will then approve or revise the request, assign a priority to it, and establish an expected completion date.

Weekly and monthly status meetings shall be held between the District and Contractor-designated system modification/maintenance staff at the District premises, unless the District elects to meet at the Contractor's facility. The weekly meeting will allow the Contractor to report progress against schedules and any necessary schedule revisions, and shall allow for discussion of specific details where necessary. When appropriate, the deliverables presented during the week may be discussed. The monthly meetings for managerial staff shall be documented, in writing, by the Contractor and shall be conducted so as to provide a synopsis of the highlights of the month's weekly meetings.

All completed work requests shall be retained for documentation and analytical purposes.

In addition to reporting on each completed work request, the monthly report shall include a summary log that lists all outstanding requests and the estimated staff hours to complete them, by status and priority, for work activity.

C.9.4 DISTRICT RESPONSIBILITIES

Where maintenance activity has been determined or a modification is required:

1. Prepare and submit to the Contractor a written change request (CSR) when a modification is required;
2. Receive and review notices of maintenance support or proposed work requests from Contractor;
3. Review and approve corrective action plan for maintenance support;
4. Determine priority for Contractor completion of work requests and return approved requests with priority assigned;
5. Assist the Contractor in conducting a detailed requirements analysis on any major changes as required;
6. Review and approve the Requirements Specifications Document;
7. Review and approve the detailed design for changes, when one is required;
8. Monitor Contractor work request activities;
9. Review and approve required test plans, including testing responsibilities;
10. Assist in development of test data;
11. Review and approve required test results;
12. Review and approve updates to system documentation;
13. Review and approve updates to user and provider manuals and operations procedures (if required);
14. Approve implementation of modification; and
15. Provide technical signoff that modification is approved.

C.9.5 MODIFICATION TASK CONTRACTOR RESPONSIBILITIES

Where maintenance support is required:

1. Receive the notification of discrepancy on a work request from the District;
2. Inform the District when a system deficiency is identified, within twenty-four (24) hours of discovery;
3. Enter the work request (CSR) identifying the maintenance support into a tracking system;
4. Present the District with a corrective action plan for approval;
5. Receive an approved work request from the District;
6. Take corrective action;
7. Submit test plan, including testing responsibilities, when required by the District;
8. Conduct systems test;
9. Submit test results to the District;
10. Submit updates to systems documentation;
11. Submit updates to user and provider manuals and operations procedures (if required);
12. Implement correction upon District approval; and
13. Prepare and distribute final form of manuals and system documentation within one week of technical sign off.

Where modification support is requested:

1. Receive change request (CSR) from the District;
2. Submit a work request for Contractor-proposed changes;
3. Conduct detailed requirements analysis for major changes;
4. Submit requirements analysis and specifications to District for approval,
5. Prepare an estimate of staff effort and schedule, including impact on other projects and priorities;
6. For minor changes, prepare a description of the required modifications;
7. For major changes, develop detailed design documentation, including inputs, outputs, flow charts, file/database changes, program narrative and logic, program flow charts, test plan, and user documentation, when required by DOH;
8. Prepare and submit a test plan for approval, when required by MAA;
9. Code programs/modifications;

10. Perform systems test;
11. Submit test results to District;
12. Submit updates to systems documentation;
13. Submit updates to user and provider manuals and operating procedures (if required);
14. Implement modifications upon District approval; and
15. Prepare and distribute final form manuals and MMIS system documentation within one week of technical signoff.

If the Contractor and the District agree that the change request cannot be accomplished with the available staff and hours (inclusive of the four thousand [4,000] hours available for modification support), the Contractor shall respond with a detailed proposal, within ten (10) days, containing:

1. A statement of the scope of the change request in relation to subsystems, functions, features, and capabilities to be changed;
2. A breakdown of the work effort by milestone;
3. A breakdown of the work effort by hour within each job classification required;
4. A rate per hour for each job classification required with a total proposed amount;
5. An implementation schedule for the change request and, if appropriate, revised schedules for all other concurrently approved projects or change requests affected by the current change request; and
6. A justification for the additional staff, rates, and schedules.

The District will review the proposal and, if approved, prepare a contract modification as stated in Section H.26.

A change request is deemed successfully completed when:

1. It has been cancelled by the COTR in writing; or
2. The Contractor has received a technical sign off initially signed by an authorized District representative(s) and co-signed by the COTR;
3. The maintenance activity or modification has been successfully tested and approved by the COTR or has run in production for thirty (30) calendar days or through a complete production cycle; and
4. All documentation has been drafted, approved by the District, and produced and distributed in final form.

C.10 TURNOVER TASK

Prior to the conclusion of the contract, the Contractor shall provide, at no extra charge, assistance computer facilities, systems, and communications facilities in turning over the enhanced MMIS to the District or its agent.

C.10.1 DISTRICT RESPONSIBILITIES

District responsibilities are to:

1. Review and approve a Turnover plan to facilitate transfer of the District of Columbia MMIS to the District or its designated agent;
2. Review and approve a statement of staffing and hardware resources which would be required to take over operation of the District of Columbia MMIS;
3. Request Turnover services be initiated by the Contractor;
4. Make District staff or designated Contractor staff available to be trained in the operation of the MMIS;
5. Coordinate the transfer of MMIS software and files;
6. Coordinate the termination or assumption of leases of MMIS hardware and software;
7. Review and approve a Turnover Results Report that documents completion of each step of the Turnover Plan; and
8. Obtain post-Turnover support from the Contractor at no extra charge for ninety (90) days following contract termination, if required.

C.10.2 TURNOVER TASK CONTRACTOR RESPONSIBILITIES

The Contractor shall be responsible for Turnover activities described in the following subsections.

C.10.2.1 Develop a MMIS Turnover Plan

Before the start of the last year of the contract period, or at such time as the District may designate, the Contractor shall provide, at no additional cost, a Turnover Plan to the District. The plan shall include:

1. Proposed approach to Turnover,
2. Tasks and subtasks for Turnover,
3. Schedule for Turnover, and
4. Production program and documentation update procedures during Turnover.

C.10.2.2 Develop a MMIS Requirements Statement

Prior to the start of the last year of the contract period, or at such time as the District may designate, the Contractor shall furnish to the District, at no extra charge, a statement of the resources that would be required by the District or another Contractor to take over operation of the MMIS:

1. The statement must include an estimate of the number, type, and salary of personnel required to operate the equipment and perform the other functions of the District of Columbia MMIS. The statement shall be separated by type of activity of the personnel, including, but not limited to, the following categories:
   a) Data processing staff;
   b) Computer operators;
   c) Systems analysts;
   d) Systems programmers;
   e) Programmer analysts;
   f) Data entry operators;
   g) Administrative staff;
   h) Clerks;
   i) Managers;
   j) Medical personnel (nurses, MDs, pharmacists, and so forth);
2. The statement shall include all facilities and any other resources required to operate the District of Columbia MMIS, including, but not limited to:
   a) Data processing equipment,
   b) System and special software,
   c) Other equipment,
   d) Telecommunications networks,
   e) Office space,
   f) Other; and
3. The statement of resource requirements shall be based on the Contractor's experience in the operation of the MMIS and shall include actual Contractor resources devoted to the operation of the system.

C.10.2.3 Provide Turnover Service

As requested by the District, at such time as the District may designate, or approximately six (6) months prior to the end of the contract period, the Contractor shall transfer all current source program code listings to the District.

As requested, at such time as the District may designate, or approximately six (6) months prior to the end of the contract period, the Contractor shall transfer to the District or its agent, as needed, a copy of the enhanced MMIS, including:

1. All necessary data and reference files on magnetic cartridge;
2. All production computer programs on magnetic cartridge;
3. JCL on magnetic cartridge;
4. Data entry software;
5. All other documentation, including, but not limited to, user, provider, and operation manuals needed to operate and maintain the system on PC-compatible diskettes, using District-approved software;
6. Procedures for updating computer programs, JCL, and other documentation;
7. All archived JCL sysout to include, at a minimum, job control statements executed, condition codes, system messages, start and stop dates and times, CPU time used, clock time used, and final file dispositions for each job step on magnetic cartridge, in a format specified by the District;
8. All operations logs, process summaries, and balancing documents completed during the contract;
9. All job scheduling software and reports used by operations;
10. Hardware configuration diagram showing the relationship between all data processing and communication equipment necessary to operate the MMIS, including, but not limited to, local area networks, EMC support networks, control units, remote job entry devices, storage devices, printers, control units, and data entry devices; and
11. All system macros (such as panels, skeletal JCL, and CLISTs developed in TSO/ISPF) used for job scheduling, data entry or system modification functions.

As requested, or approximately five (5) months prior to the end of the contract or any extension thereof, the Contractor shall begin training the staff of the District or its designated agent in the operation of the MMIS. Such training shall be completed at least two (2) months prior to the end of the contract or any extension thereof. Such training shall include:

1. Claims processing data entry;
2. Computer operations, including cycle monitoring procedures;
3. Controls and balancing procedures;
4. Exception claims processing; and
5. Other manual procedures.

As requested, or approximately four (4) months prior to the end of the contract or any extension thereof, the Contractor shall provide updates to replacements for all data and

reference files, computer programs, JCL, and all other documentation as shall be required by the District or its agent to run acceptance tests.

At the option of the District, the Contractor shall arrange for the removal of MMIS hardware and software.

At a Turnover date to be determined by DOH, the Contractor shall provide to the District or its agent all updated computer programs, data and reference files, JCL, and all other documentation and records as shall be required by the District or its agent to operate the District of Columbia MMIS.

Following Turnover of operations, the Contractor shall provide the District with a Turnover Results Report that will document completion and results of each step of the Turnover Plan.

C.10.2.4 Update MMIS Turnover Plan

Upon District request or at least six (6) months prior to the end of the base contract, the Contractor shall provide an updated MMIS Turnover Plan and MMIS Requirements Statement.

C.10.2.5 Provide Post-Turnover Services

In order to provide post-Turnover support, the Contractor shall provide, at no charge to the District, the services of an on-site systems analyst who has worked on the District of Columbia MMIS at least one (1) year. This individual shall be required to be on-site for the ninety (90) days following contract termination. The individual proposed by the Contractor must be approved by the District. The District will provide working space and will assign work to be done on a full-time basis to support post-Turnover activity.

The Contractor shall also be responsible for, and shall correct, at no cost, any malfunctions which existed in the system prior to Turnover or which were caused by lack of support at Turnover, as may be determined by the District.

C.10.3 MILESTONES

The milestones for this task are:

1. District approval of Turnover Plan,
2. District approval of MMIS Requirements Statement,
3. District request for Turnover services,
4. Completion of Turnover training, and
5. Completion of Turnover.

C.10.4 DELIVERABLES

The deliverables for this task are:

1. Turnover Plan,
2. MMIS Requirements Statement,
3. MMIS software, files, and operations documentation, and
4. Turnover Results Report

SECTION D: PACKAGING AND MARKING

This section is not applicable to this solicitation.

SECTION E: INSPECTION AND ACCEPTANCE

This section is not applicable to this solicitation.

SECTION F: DELIVERIES OR PERFORMANCE

F.1 TERM OF CONTRACT

The term of the contract shall be for a period of seven (7) years from the date of award.

F.2 DELIVERABLES

Item No.	Deliverable	Quantity	Format/Method of Delivery	Due Date	To Whom
001	C.7.15.7.5 Design Subtask	7	Electronic/Hardcopy	1month after Contract Award	COTRs
002	C.7.15.5 Development/ Testing Subtask	7	Electronic/Hardcopy	1 month after approval of Item No. 001	COTRs
003	C.7.18.1.3 Conversion Subtask	7	Electronic/Hardcopy	1 month after approval of Item No. 002	COTRs
004	C.7.19.10 Acceptance Testing Subtask	7	Electronic/Hardcopy	1 month after approval of Item No. 003	COTRs
005	C.7.20.4 Preparations of Operations Subtask	7	Electronic/Hardcopy	1 month after approval of Item No. 004	COTRs
006	C.5.7.3 & H.37.1 CMS Certification	7	Electronic/Hardcopy	1 year after approval of Item No. 005	COTRs
007	C.10.4 Turnover Subtask	7	Electronic/Hardcopy	6 months before contract expiration date	COTRs

F.2.1 The Contractor shall submit to the District, as a deliverable, the report described in section H.4 of this contract that is required by the 51% District Residents New Hires Requirements and First Source Employment Agreement. If the Contractor does not submit the report as part of the deliverables, final payment to the Contractor may not be paid.

SECTION G : CONTRACT ADMINISTRATION DATA

G.1 INVOICE PAYMENT

G.1.1 The District will make payments to the Contractor, upon the submission of proper invoices, at the prices stipulated in this contract, for supplies delivered and accepted or services performed and accepted, less any discounts, allowances or adjustments provided for in this contract.

G.1.2 The District will pay the Contractor on or before the 30th day after receiving a proper invoice from the Contractor.

G.2 INVOICE SUBMITTAL

G.2.1 The Contractor shall submit proper invoices on a monthly basis or as otherwise specified in Section G.4. Invoices shall be prepared in duplicate and submitted to the Agency Fiscal Officer with concurrent copies to the Contracting Officer's Technical Representative (COTR) specified in Section G.9 below. The address of the CFO is:

Name: Office of the Controller/Agency Fiscal Officer
Address: Department of Health
825 North Capitol Street, NE
Washington, DC 20002
Telephone: 202-442-9231

G.2.2 To constitute a proper invoice, the Contractor shall submit the following information on the invoice:

G.2.2.1 Contractor's name, federal tax ID and invoice date (Contractors shall date invoices as of the date of mailing or transmittal);

G.2.2.2 Contract number and invoice number;

G.2.2.3 Description, price, quantity and the date(s) that the supplies or services were delivered or performed;

G.2.2.4 Other supporting documentation or information, as required by the Contracting Officer;

G.2.2.5 Name, title, telephone number and complete mailing address of the responsible official to whom payment is to be sent;

G.2.2.6 Name, title, phone number of person preparing the invoice;

G.2.2.7 Name, title, phone number and mailing address of person (if different from the person identified in G.2.2.6 above) to be notified in the event of a defective invoice; and

G.2.2.8 Authorized signature.

G.3 FIRST SOURCE AGREEMENT REQUEST FOR FINAL PAYMENT

G.3.1 For contracts subject to the 51% District Residents New Hires Requirements and First Source Employment Agreement requirements, final request for payment must be accompanied by the report or a waiver of compliance discussed in section H.36.5.

G.3.2 No final payment shall be made to the Contractor until the CFO has received the Contracting Officer' s final determination or approval of waiver of the Contractor' s compliance with 51% District Residents New Hires Requirements and First Source Employment Agreement requirements.

G.4 PAYMENT

Payment will be made upon verification and certification of invoices by the District and as set forth in Sections H.21 through H.23.

G.5 ASSIGNMENT OF CONTRACT PAYMENTS

G.5.1 In accordance with 27 DCMR 3250, the Contractor may assign funds due or to become due as a result of the performance of this contract to a bank, trust company, or other financing institution.

G.5.2 Any assignment shall cover all unpaid amounts payable under this contract, and shall not be made to more than one party.

G.5.3 Notwithstanding an assignment of contract payments, the Contractor, not the assignee, is required to prepare invoices. Where such an assignment has been made, the original copy of the invoice must refer to the assignment and must show that payment of the invoice is to be made directly to the assignee as follows:

> Pursuant to the instrument of assignment dated _____,
> make payment of this invoice to _____
> (name and address of assignee).

G.6 THE QUICK PAYMENT CLAUSE

G.6.1 Interest Penalties to Contractors

G.6.1.1 The District will pay interest penalties on amounts due to the Contractor under the Quick Payment Act, D.C. Official Code §2-221.01 et seq., for the period beginning on the day after the required payment date and ending on the date on which payment of the amount is made. Interest shall be calculated at the rate of 1% per month. No interest penalty shall be paid if payment for the completed delivery of the item of property or service is made on or before:

a) the 3rd day after the required payment date for meat or a meat product;
b) the 5th day after the required payment date for an agricultural commodity; or
c) the 15th day after the required payment date for any other item.

G.6.1.2 Any amount of an interest penalty which remains unpaid at the end of any 30-day period shall be added to the principal amount of the debt and thereafter interest penalties shall accrue on the added amount.

G.6.2 Payments to Subcontractors

G.6.2.1 The Contractor must take one of the following actions within 7 days of receipt of any amount paid to the Contractor by the District for work performed by any subcontractor under a contract:

a) Pay the subcontractor for the proportionate share of the total payment received from the District that is attributable to the subcontractor for work performed under the contract; or
b) Notify the District and the subcontractor, in writing, of the Contractor' s intention to withhold all or part of the subcontractor' s payment and state the reason for the nonpayment.

G.6.2.2 The Contractor must pay any lower-tier subcontractor or supplier interest penalties on amounts due to the subcontractor or supplier beginning on the day after the payment is due and ending on the date on which the payment is made. Interest shall be calculated at the rate of 1% per month. No interest penalty shall be paid on the following if payment for the completed delivery of the item of property or service is made on or before:

a) the 3rd day after the required payment date for meat or a meat product;
b) the 5th day after the required payment date for an agricultural commodity; or
c) the 15th day after the required payment date for any other item.

G.6.2.3 Any amount of an interest penalty which remains unpaid by the Contractor at the end of any 30-day period shall be added to the principal amount of the debt to the subcontractor and thereafter interest penalties shall accrue on the added amount.

G.6.2.4 A dispute between the Contractor and subcontractor relating to the amounts or entitlement of a subcontractor to a payment or a late payment interest penalty under the Quick Payment Act does not constitute a dispute to which the District of Columbia is a party. The District of Columbia may not be interpleaded in any judicial or administrative proceeding involving such a dispute.

G.7 CONTRACTING OFFICER (CO)

Contracts will be entered into and signed on behalf of the District only by contracting officers. The name, address and telephone number of the Contracting Officer is:

William Sharp
Office of Contracting and Procurement
Address: 441 4th Street, NW, Suite 700 South
Washington, DC 20001
Telephone: (202) 727-0252

G.8 AUTHORIZED CHANGES BY THE CONTRACTING OFFICER

G.8.1 The Contracting Officer is the only person authorized to approve changes in any of the requirements of this contract.

G.8.2 The Contractor shall not comply with any order, directive or request that changes or modifies the requirements of this contract, unless issued in writing and signed by the Contracting Officer.

G.8.3 In the event the Contractor effects any change at the instruction or request of any person other than the Contracting Officer, the change will be considered to have been made without authority and no adjustment will be made in the contract price to cover any cost increase incurred as a result thereof.

G.9 CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR)

G.9.1 The COTR is responsible for general administration of the contract and advising the Contracting Officer as to the Contractor's compliance or noncompliance with the contract. In addition, the COTR is responsible for the day-to-day monitoring and supervision of the contract, of ensuring that the work conforms to the requirements of this contract and such other responsibilities and authorities as may be specified in the contract. The COTR for this contract is:

Name: Yohannes Birre
Title: Systems Manager
Agency: Department of Health
Medical Assistance Administration
Address: 2100 Martin Luther King Jr., Avenue, SE
Washington, DC 20020
Telephone: (202) 698-2014

G.9.2 The COTR shall not have authority to make any changes in the specifications or scope of work or terms and conditions of the contract.

G.9.3 The Contractor may be held fully responsible for any changes not authorized in advance, in writing, by the Contracting Officer; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.

G.9.4 COST REIMBURSEMENT CEILING

a) The cost reimbursement ceilings for this RFP shall not exceed $7,000.00 per month over the seven (7) year period.

b) The costs for performing this RFP shall not exceed the cost reimbursement ceiling as set forth in the RFP.

c) The Contractor agrees to use its best efforts to perform the work specified in this RFP and to meet all obligations under this RFP within the cost reimbursement ceilings.

d) The Contractor must notify the Contracting Officer, in writing, whenever it has reason to believe that the total cost for the performance of this RFP will be either greater or substantially less than the cost reimbursement ceilings.

e) As part of the notification, the Contractor must provide the Contracting Officer a revised estimate of the total cost of performing this RFP.

f) The District is not obligated to reimburse the Contractor for costs incurred in excess of the cost reimbursement ceiling specified in B.2 listed in the RFP and the Contractor is not obligated to continue performance under this RFP (including actions under the Termination clauses of this RFP), or otherwise incur costs in excess of the cost reimbursement ceilings specified in B.2 listed in the RFP, until the Contracting Officer notifies the Contractor, in writing, that the estimated cost has been increased and provides revised cost reimbursement ceilings for performing this RFP.

g) No notice, communication, or representation in any form from any person other than the Contracting Officer shall change the cost reimbursement ceilings. In the absence of the specified notice, the District is not obligated to reimburse the Contractor for any costs in excess of the costs reimbursement ceilings, whether such costs were

incurred during the course of contract performance or as a result of termination.

h) If any cost reimbursement ceiling specified in B.2 listed in the RFP is increased, any costs the Contractor incurs before the increase that are in excess of the previous cost reimbursement ceiling shall be allowable to the same extent as if incurred afterward, unless the Contracting Officer issues a termination or other notice directing that the increase is solely to cover termination or other specified expenses.

i) A change order shall not be considered an authorization to exceed the applicable cost reimbursement ceiling specified in B.2 as set forth in the RFP, unless the change order specifically increases the cost reimbursement ceiling.

G.10 **ORDERING CLAUSE**

a. Any supplies and services to be furnished under the contract must be ordered by issuance of delivery orders or task orders by the Contracting Officer. Such orders may be issued monthly, quarterly, or annually as services are required during the term of the contract.
b. All delivery orders are subject to the terms and conditions of this contract. In the event of a conflict between a delivery order and the contract, the contract shall control.
c. If mailed, a delivery order is considered "issued" when the District deposits the order in the mail. Orders may be issued by facsimile or by electronic commerce methods.

SECTION H: SPECIAL CONTRACT REQUIREMENTS

H.1 HIRING OF DISTRICT RESIDENTS AS APPRENTICES AND TRAINEES

H.1.1 For all new employment resulting from this contract or subcontracts hereto, as defined in Mayor's Order 83-265 and implementing instructions, the Contractor shall use its best efforts to comply with the following basic goal and objectives for utilization of bona fide residents of the District of Columbia in each project's labor force:

H.1.1.1 At least fifty-one (51) percent of apprentices and trainees employed shall be residents of the District of Columbia registered in programs approved by the District of Columbia Apprenticeship Council.

H.1.2 The Contractor shall negotiate an Employment Agreement with the DOES for jobs created as a result of this contract. The DOES shall be the Contractor's first source of referral for qualified apprentices and trainees in the implementation of employment goals contained in this clause.

H.2 DEPARTMENT OF LABOR WAGE DETERMINATIONS

The Contractor shall be bound by the Wage Determination No. 1994-2103, Revision No. 35, dated May 23, 2006 issued by the U.S. Department of Labor in accordance with the Service Contract Act (41 U.S.C. 351 et seq.) and incorporated herein as Section J.1.1 of this solicitation. The Contractor shall be bound by the wage rates for the term of the contract. If an option is exercised, the Contractor shall be bound by the applicable wage rate at the time of the option. If the option is exercised and the Contracting Officer obtains a revised wage determination, the revised wage determination is applicable for the option periods and the Contractor may be entitled to an equitable adjustment.

H.3 FREEDOM OF INFORMATION ACT

The District of Columbia Freedom of Information Act, at D.C. Official Code § 2-532 (a-3), requires the District to make available for inspection and copying any record produced or collected pursuant to a District contract with a private Contractor to perform a public function, to the same extent as if the record were maintained by the agency on whose behalf the contract is made. If the Contractor receives a request for such information, the Contractor shall immediately send the request to the COTR designated in subsection G.9 who will provide the request to the FOIA Officer for the agency with programmatic responsibility in accordance with the D.C. Freedom of Information Act. If the agency with programmatic responsibility receives a request for a record maintained by the Contractor pursuant to the contract, the COTR will forward a copy to the Contractor. In either event, the Contractor is required by law to provide all responsive records to the COTR within the timeframe designated by the COTR. The FOIA Officer for the agency with programmatic

responsibility will determine the releasability of the records. The District will reimburse the Contractor for the costs of searching and copying the records in accordance with D.C. Official Code §2-532 and Chapter 4 of Title 1 of the *D.C. Municipal Regulations*.

H.4 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT

H.4.1 The Contractor shall comply with the First Source Employment Agreement Act of 1984, as amended, D.C. Official Code §2-219.01 et seq. ("First Source Act").

H.4.2 The Contractor shall enter into and maintain, during the term of the contract, a First Source Employment Agreement, (Section J.2.4) in which the Contractor shall agree that:

(1) The first source for finding employees to fill all jobs created in order to perform this contract shall be the Department of Employment Services ("DOES"); and

(2) The first source for finding employees to fill any vacancy occurring in all jobs covered by the First Source Employment Agreement shall be the First Source Register.

H.4.3 The Contractor shall submit to DOES, no later than the 10th each month following execution of the contract, a First Source Agreement Contract Compliance Report ("contract compliance report") verifying its compliance with the First Source Agreement for the preceding month. The contract compliance report for the contract shall include the:

(1) Number of employees needed;
(2) Number of current employees transferred;
(3) Number of new job openings created;
(4) Number of job openings listed with DOES;
(5) Total number of all District residents hired for the reporting period and the cumulative total number of District residents hired; and
(6) Total number of all employees hired for the reporting period and the cumulative total number of employees hired, including:
  (a) Name;
  (b) Social security number;
  (c) Job title;
  (d) Hire date;
  (e) Residence; and
  (f) Referral source for all new hires.

H.4.4 If the contract amount is equal to or greater than $100,000, the Contractor agrees that 51% of the new employees hired for the contract shall be District residents.

H.4.5 With the submission of the Contractor' s final request for payment from the District, the Contractor shall:

(1) Document in a report to the Contracting Officer its compliance with the section H.36.4 of this clause; or
(2) Submit a request to the Contracting Officer for a waiver of compliance with section H.4.4 and include the following documentation:

(a) Material supporting a good faith effort to comply;
(b) Referrals provided by DOES and other referral sources;
(c) Advertisement of job openings listed with DOES and other referral sources; and
(d) Any documentation supporting the waiver request pursuant to section H.36.6.

H.4.6 The Contracting Officer may waive the provisions of section H.4.4 if the Contracting Officer finds that:

(1) A good faith effort to comply is demonstrated by the Contractor;
(2) The Contractor is located outside the Washington Standard Metropolitan Statistical Area and none of the contract work is performed inside the Washington Standard Metropolitan Statistical Area which includes the District of Columbia; the Virginia Cities of Alexandria, Falls Church, Manassas, Manassas Park, Fairfax, and Fredericksburg, the Virginia Counties of Fairfax, Arlington, Prince William, Loudoun, Stafford, Clarke, Warren, Fauquier, Culpeper, Spotsylvania, and King George; the Maryland Counties of Montgomery, Prince Georges, Charles, Frederick, and Calvert; and the West Virginia Counties of Berkeley and Jefferson.
(3) The Contractor enters into a special workforce development training or placement arrangement with DOES; or
(4) DOES certifies that there are insufficient numbers of District residents in the labor market possessing the skills required by the positions created as a result of the contract.

H.4.7 Upon receipt of the Contractor's final payment request and related documentation pursuant to sections H.4.5 and H.4.6, the Contracting Officer shall determine whether the Contractor is in compliance with section H.4.4 or whether a waiver of compliance pursuant to section H.4.6 is justified. If the Contracting Officer determines that the Contractor is in compliance, or that a waiver of compliance is justified, the Contracting Officer shall, within two business days of making the determination forward a copy of the determination to the Agency Chief Financial Officer and the COTR.

H.4.8 Willful breach of the First Source Employment Agreement, or failure to submit the report pursuant to section H.4.5, or deliberate submission of falsified data, may be enforced by the Contracting Officer through imposition of penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract. The Contractor shall make payment to DOES. The Contractor may appeal to the D.C. Contract Appeals Board as provided in the contract any decision of the Contracting Officer pursuant to this section H.4.8.

H.4.9 The provisions of sections H.4.4 through H.4.8 do not apply to nonprofit organizations.

H.5 PROTECTION OF PROPERTY:

The Contractor shall be responsible for any damage to the building, interior, or their approaches in delivering equipment covered by this contract.

H.6 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

During the performance of the contract, the Contractor and any of its subcontractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability.
See 42 U.S.C. §12101 et seq.

H.7 SECTION 504 OF THE REHABILITATION ACT OF 1973, as amended.

During the performance of the contract, the Contractor and any of its subcontractors shall comply with Section 504 of the Rehabilitation Act of l973, as amended. This Act prohibits discrimination against disabled people in federally funded program and activities. See 29 U.S.C. §794 et seq.

H.8 CONTRACT ADMINISTRATION

H.8.1 The contract will be administered for the District by the Department of Health (DOH), Medical Assistance Administration (MAA). The COTR shall be responsible for project direction and contract management.

H.8.2 The COTR shall be the Contractor's primary liaison in working with other MAA staff. The COTR will initially receive and review all Contractor progress reports and deliverables, oversee scheduling of meetings with District staff, and maintain first-line administrative responsibility for the contract.

H.8.3 In no instance shall the Contractor refer any matter to any other MAA official unless initial contact, both verbal and in writing, regarding the matter has been presented to the COTR. The COTR will chair the weekly status meetings during the Enhancement and Implementation Task and attend all formal project walk-through.

H.8.4 All notices regarding the failure to meet performance requirements and any assessments of damages under the provisions set forth in this chapter shall be issued by the Contracting Officer.

H.8.5 The Contractor shall designate a Contract Manager who shall have the authority to enter into any modifications on behalf of the Contractor and otherwise commit the Contractor to any course of action, undertaking, obligation or responsibility in connection with the Contractor's performance of this Contract.

H.8.6 The Contractor shall designate a Project Manager who shall have day to day responsibility for supervising the performance of the Contractor's obligations under the Contract. The Contractor shall not change the designation of its Contract Manager or its Project Manager without the Contracting Officer's prior written approval, which approval shall not be unreasonably delayed or withheld.

H.9 NOTICES

Whenever notice is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if a signed receipt is obtained when delivered by hand or three (3) days after posting if sent by registered or certified mail, return receipt requested. Notices shall be addressed as follows:

In case of notice to the Contractor:

MMIS Project/Account Manager
Address of Local Facility in the District of Columbia

In case of notice to MAA:

COTRs
District of Columbia
Department of Health
Medical Assistance Administration
2100 Martin Luther King Jr. Avenue, S.E.
Washington, DC 20020

Said notices shall become effective on the date of receipt or the date specified within the notice, whichever comes later. Either party may change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

H.10 LOCATION OF CONTRACTOR FACILITIES

Due to the nature of the contract and the need for close coordination with the Medical Assistance Administration's personnel, the Contractor shall maintain an office in District of Columbia to house the Contractor's staff during the life of the Contract for performance of MMIS Enhancement and Implementation and Operations Task functions including, but not limited to:

1. Contract administration/District liaison (key personnel);
2. Claims receipt, prescreening, and putting claims and other documents to microform;
3. Data entry (hard-copy and EMC transactions);
4. Exception claims processing (suspense resolution)
5. Check request-related activities;
6. Business operations (check requests to District Treasurer, accounts receivable handling, cash activity);
7. Production of newsletters, manuals, and so forth;
8. Provider relations and provider enrollment; and

9. Report printing (except MARS and utilization management).

H.10.1 The location of the Contractor's computer installation(s) for all MMIS functions and tasks shall be approved by the Medical Assistance Administration. The Contractor shall not change the location(s) of its facility(s) except for good cause and with the prior written consent of the Contracting Officer, which consent shall not be unreasonably withheld.

H.10.2 In addition, the Contractor shall maintain, and make available, office space for three (3) Medical Assistance Administration personnel for the entire duration of the MMIS Enhancement and Implementation Task, and two (2) Medical Assistance Administration personnel for the remaining term of the Contract. This space shall be contiguous with the Contractor's project staff during the respective tasks.

H.11 COOPERATION IN HEARINGS AND DISPUTES

The Contractor shall cooperate and participate in the resolution of Departmental Fair Hearings and Provider Disputes at the request of the Medical Assistance Administration.

H.12 COOPERATION IN FRAUD INVESTIGATIONS

The Contractor shall cooperate fully with the US Department of Health and Human Services, the District of Columbia Department of Health, and any other authorized local, District and federal agencies or law enforcement authorities in the investigation, documentation and litigation of possible fraud and abuse cases or any other misconduct involving any of the duties and responsibilities performed by the Contractor under the Contract. The Contractor shall agree that the US Department of Health and Human Services, its authorized representatives, and those of the District of Columbia Department of Health shall have access to the same records and information as does the District of Columbia Department of Health.

H.13 SUBMISSION AND ACCEPTANCE OF SUBTASKS DELIVERABLES

H.13.1 The Contractor shall perform its tasks and produce the required Deliverables by the due dates presented in the Contractor's Response to RFP Requirements C.7 and C.8 for the MMIS Enhancement and Implementation and Operations Tasks. The Contractor shall deliver each Deliverable to the COTR, clearly identified as a Deliverable to distinguish it from other material.

H.13.2 As soon as possible, but in no event later than ten (10) business days after receipt of a Deliverable, the COTR will give written notice to the Contractor of the Medical Assistance Administration's unconditional approval, conditional approval or disapproval. Notice of conditional approval or disapproval shall state the reasons for such conditions or disapproval as specifically as is reasonably necessary to indicate

the nature and extent of the corrections required to qualify the Deliverable for approval.

H.13.3 As soon as possible, but in no event later than seven (7) business days after receipt of a notice of conditional approval or disapproval, the Contractor shall make the corrections and resubmit the corrected Deliverable.

H.13.4 As soon as possible, but in no event later than ten (10) business days following resubmission of any conditionally approved or originally disapproved Deliverable, the COTR shall give written notice to the Contractor of the Medical Assistance Administration's unconditional approval, conditional approval or disapproval.

H.13.5 In the event that the COTR fails to respond to a Deliverable (such as, to give notice of unconditional approval, conditional approval or disapproval as aforesaid) within the applicable time period, the Contractor shall elect either of the following two (2) courses:

1. Notify the COTR in writing that it intends to proceed with subsequent work unless the response is received by a date to be specified in such notice. The date specified shall not be earlier than five (5) business days following the date of receipt of the notice. If the response is not delivered by the specified date, the Deliverable shall be deemed to have been unconditionally approved on that day and the Contractor shall not be entitled to any equitable adjustment in time or price on account of any delay; or

2. Notify the COTR in writing that a response is required, and that it intends to delay subsequent work unless the response is received by a date to be specified in such notice. The date specified shall not be earlier than five (5) business days following the date of receipt of the notice. If the response is not delivered by the specified date, the Contractor shall apply in writing to the COTR and in accordance with Subsection H.34, "SUSPENSION OF WORK," with any claims for delay, providing adequate substantiation therefore.

H.13.6 By submitting a Deliverable, the Contractor represents that to the best of its knowledge, it has performed the associated tasks in a manner that will, in concert with other tasks, meet the objectives stated or referred to in the Contract. By unconditionally approving a Deliverable, the Medical Assistance Administration represents only that it has reviewed the Deliverable and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the withholding or denial of payment for the work completed. The Medical Assistance Administration's approval of a Deliverable does not discharge any of the Contractor's contractual obligations with respect to that Deliverable, or to the quality, comprehensiveness, functionality, effectiveness or certification of the District of Columbia MMIS as a whole.

H.14 COMPLETION OF MILESTONES

H.14.1 The completion of a Milestone as defined in Section C.7.5 and C.7.6 shall be indicated by the unconditional written approval of all Deliverables as defined in Section F.2 comprising each Milestone by the Medical Assistance Administration.

H.14.2 Upon the Medical Assistance Administration's unconditional approval of all Deliverables comprising each Milestone during the MMIS Enhancement and Implementation Task, the Contractor shall, at the written request of the COTR, provide a structured walk-through of the entire MMIS, including copies of support documentation and any visual aids normally used for this purpose for such District and Federal personnel as the COTR may select. The Contractor shall conduct each presentation at the time and place convenient to the District and Federal personnel in attendance as specified in the Medical Assistance Administration's written request.

H.14.3 The Contractor may proceed to perform work on a succeeding Milestone during the MMIS Enhancement and Implementation Task prior to the Medical Assistance Administration's unconditional approval of all Deliverables comprising a preceding Milestone only upon the conditions that all such work performed shall be entirely at its own risk and that the Medical Assistance Administration shall have no obligation to work in concert with the Contractor or review any Deliverables relating to the succeeding Milestone(s). The Contractor shall be solely responsible for all costs relating to any changes, deletions or additions it may be required to make as a result of its failure to obtain all unconditional approvals for Deliverables comprising a Milestone.

H.15 DUE DATES

Whenever the due date as defined in Section F.2 for any Deliverable, or the final day on which an act is permitted or required by this Contract to be performed by either party fall(s) on a day other than a business day, such date shall be the first business day following such day.

H.16 STATUS REPORTS AND CONSULTATION

H.16.1 Once each week, or at more frequent intervals as the parties may agree, until the commencement of the MMIS Operations Task, the MMIS Enhancement and Implementation Project Manager and his necessary staff shall meet with the District of Columbia COTR and selected staff to discuss the Contractor's progress and performance under the Contract.

H.16.2 No later than the fifth (5^{th}) calendar day of each month commencing with the start of the MMIS Enhancement and Implementation Task and continuing for the life of the contract, the Contractor shall submit two (2) copies of a written MMIS progress report as defined in Section C.7.1thorough C.7.5 to the COTR. The second copy shall be included in the monthly status report to CMS. Each MMIS progress report shall provide a detailed description of the status of the Contractor's progress and

performance under the contract since the last progress report and shall be signed by the MMIS Enhancement and Implementation or Operations Project Manager (as appropriate to the MMIS Task) or his or her designee.

1. Prior to the commencement of the MMIS Operations Task, each written MMIS progress report shall describe the tasks and deliverables completed, the tasks and deliverables scheduled for completion but not completed and reasons for such failure to complete, and the progress expected to be made in the next reporting period. All work activities described shall be referenced to the approved work plan.

2. Subsequent to the commencement of the MMIS Operations Task, each written MMIS progress report shall describe any problems the Contractor has encountered in the performance of any of its responsibilities under the Contract including but not limited to downtime episodes. Each report shall detail any problems discovered in the application software with emphasis on any system abnormalities or failures caused by the application problems and the corrective action taken and planned to prevent the failures or abnormalities from occurring or recurring. In addition, each report shall include the status of all change orders proposed, in negotiation, in development, in testing or awaiting Medical Assistance Administration technical sign-off, the required staffing reports, and proposed production schedules for the current and two (2) subsequent months.

H.16.3 At any time during the life of the contract, upon written request by the Medical Assistance Administration, the Contractor shall promptly prepare and provide written special progress reports in response to particular problems in the performance of work under the contract identified by the Medical Assistance Administration. Each report shall include a description of the problem, the reason(s) why the problem occurred, corrective action plan(s) proposed to prevent the problem(s) from reoccurring and an implementation date for the corrective action plan(s) and shall be signed by the Project Manager.

H.16.4 At any time during the life of the contract, upon written request by the Medical Assistance Administration, the Contractor will participate in formal progress review meetings with the COTR and, other Medical Assistance Administration officials and employees and, at the option of the Medical Assistance Administration, representatives of Federal or other District agencies.

H.16.5 At any time during the life of the Contract, upon Contractor discovery of any problem which may jeopardize the successful or timely completion of its obligations, the Contractor shall notify the Medical Assistance Administration's COTR orally, no later than the close of business of that day if the problem is discovered before 5:00 p.m. or no later than 10:00 am of the succeeding business day if the problem is discovered after 5:00 p.m. The Contractor shall follow that oral notification no later than three (3) business days later with a written analysis of the problems, including in such notice the Contractor's recommendation for expeditious resolution of the problem.

H.17 POLICY DETERMINATIONS

The Medical Assistance Administration shall make and determine all policy relating to the operation of the District of Columbia MMIS. The Contractor may request of the COTR in writing that the Medical Assistance Administration issue policy determinations or operating guidelines required for proper determinations or operating guidelines required for proper performance of the Contract, in which event the COTR will deliver to the Contractor a written reply within ten (10) business days of his or her receipt of the Contractor's request. The Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines, unless and until they are superseded, suspended or revoked, so long as it does not act negligently, maliciously, fraudulently, or in bad faith.

H.18 CLAIM EDITS

H.18.1 The Contractor shall enhance the MMIS to maintain edits for all subsystems to be applied to all claims as described in Section C.6.7. The Medical Assistance Administration shall have the responsibility to establish the disposition of each edit, at any time. "Suspends" are claims which fail the edit process and must be resolved by the Contractor through internal processing, or by referral to the Medical Assistance Administration for medical review and individual consideration.

H.18.2 No edit overrides may be applied without the prior written direction or consent of the District, and the Contractor shall create and maintain an audit trail of all edit overrides.

H.19 INTERPRETATIONS

The following subsections address the provisions regarding interpretations for the District of Columbia MMIS.

H.20 CONFORMANCE WITH DISTRICT AND FEDERAL REGULATIONS

H.20.1 The Contractor agrees to comply with all District and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this contract, including those not specifically mentioned in this Section. Authority to design and develop modifications to the operational MMIS and/or to make software or operational changes to implement new District and Federal requirements will be given to the Contractor by the COTR and may entail a contract modification (see Section H.26).

H.20.2 In the event that the Contractor may, from time to time, request the District to make policy determinations or to issue operating guidelines required for proper performance of the contract, the District shall do so in a timely manner, and the Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and shall incur no liability in doing so unless the Contractor acts negligently, maliciously, fraudulently, or in bad faith.

H.21 PAYMENT

Payment for Contractor services provided under this contract will differ by task. A percentage schedule for each of the subtasks defined in Section B.4.1 for the Enhancement and Implementation will be used to calculate payments from the total prices offered. Payment for Contractor performance of Operations Task responsibilities will be paid by monthly installments of the annual fixed price offer. A cost reimbursement for postage will be paid as defined in Section G.9.4. Details of the three (3) payment approaches, available financial incentives, claim count definitions for accounting purposes, and payment request requirements are described in the following subsections.

H.22 PAYMENTS – ENHANCEMENT AND IMPLEMENTATION TASK

H.22.1 The District will pay the Contractor a firm-fixed-price for completion of all milestones for the MMIS design, development, testing and implementation, derived from the Price Schedule B.4.1 for Enhancement and Implementation Tasks.

H.22.2 The District will pay the Contractor for performance of Enhancement and Implementation Task activities in accordance with the following schedule of key contract milestones as defined in Section B.4.1:

1. District approval of all Design Subtask milestones;
2. District approval of all Development/Testing Subtask milestones;
3. District approval of all Acceptance Testing Subtask milestones;
4. District approval of all Conversion Subtask milestones;
5. District-approved Contractor start of full MMIS operations, including all reporting functions; and
6. Receipt of written approval for Federal certification of the District of Columbia MMIS.

H.22.3 The District will pay the Contractor for the successful achievement of these milestones on the following basis:

1. Twenty percent (20%) of Enhancement and Implementation Task prices offered and negotiated on Pricing Schedule B.4.1 (a) upon District approval of all Design Subtask milestones;

2. Twenty-five percent (20%) of Enhancement and Implementation Task prices offered and negotiated on Pricing Schedule B.4.1 (b) upon District approval of all Enhancement/Testing Subtask milestones;

3. Ten percent (10%) of Enhancement and Implementation Task prices offered and negotiated on Pricing Schedule B.4.1(c) upon District approval of all Conversion Subtask milestones;

4. Twenty percent (20%) of Enhancement and Implementation Task prices offered and negotiated on Pricing Schedule B.4.1(d) upon District approval of all Acceptance Testing Subtask milestones;

5. Ten percent (10%) of Enhancement and Implementation Task prices offered and negotiated on Pricing Schedule B.4.1(e) upon District-approved Contractor start of full MMIS operations, including all reporting functions; and

6. Fifteen percent (20%) of Enhancement and Implementation Task prices offered and negotiated on Pricing Schedule B.4.1 (f) upon receipt of written approval for Federal certification of the District of Columbia MMIS.

H.23 PAYMENTS - OPERATIONS TASK

H.23.1 The District will pay the Contractor the firm fixed unit price offer in the Price Schedule B.4.2 in equal monthly installments for each year period of operations. The Contractor shall be paid the firm fixed unit price offer based on the monthly rates found in Schedule B.4.3 for optional resources. Operations prices shall include all charges for system maintenance and modification support, report production, claims receipt and processing, and all other Contractor responsibilities described in Section C for that task. Postage will be considered a cost reimbursement item and subject to separate reporting and monthly invoices as described in Section G.9.4.

H.23.2 In the first month at the start of operations for which full system operation is not available, including reporting subsystems, no operations payment shall be available, nor shall it be recoverable.

H.23.3 During ongoing operations, if major portions of the system are not operational, for example, MARS and utilization management functions, the District may reduce the amount of the monthly payment by twenty-five percent (25%) for each month major portions of the system are not operational.

H.23.4 Any adjustment in the fixed unit price payable to the Contractor for operations shall be dependent on the verification and certification that actual claim volume counts are accurate and fully consistent with the explanation of a claim as given in Subsection H.24 below.

H.23.5 Contractor reimbursement for each year shall be negotiated using the same fixed unit price per year model. Final prices and estimated claim volume ranges shall be determined as part of the contract.

H.23.6 There exists no other mechanism, except Subsection H.26, "Modification Requests," by which the Contractor may receive compensation for work performed other than through the eight (8) Pricing Schedules identified in this subsection.

H.24 EXPLANATION OF A CLAIM

For the purpose of claim volume accounting and reconciliation of changes in Contractor reimbursement, the following explanation of a claim, subject to the qualifiers also noted, shall apply to administrative claims processing adjudication counts tracked and reported by the Contractor.

H.24.1 Clean Claims - is a claim that is denied or paid in its initial adjudication cycle without human intervention.

H.24.2 Unclean Claim - is a claim that was suspended during adjudication for human correction or review. The following are examples of unclean claims:

1. Inpatient/Outpatient Hospital and Home Health (UB-92) - A claim is a paper document or an EMC/X12N transaction record requesting payment for services rendered during a statement period or date range for which there are one (1) or more accommodation, HCPCS, revenue center codes, and/or ancillary codes. This includes Part A and Part B Medicare crossover claims.
2. Pharmacy Claims - A claim is each detail line item of a paper document or an EMC/X12N record requesting payment of each specific NDC code rendered to a recipient by the billing provider.
3. Nursing Home Claims (UB92 or X12N transaction 837I) - A claim is each bill for an individual recipient for all services, included in per diem rates, provided in that month by the billing provider. If line items are created for breaks in stay they are not separately reimbursed.
4. All Other Claim Types - A claim is a line item on a paper document or an EMC/X12N record requesting a total payment for services rendered to a recipient by a provider on one or more service date(s) for which there is a HCPCS or District assigned procedure code. This includes encounter claims and HMO bills.
5. Adjustments to paid claims are not countable as claims, regardless of the number of adjustments filed to a paid claim or the reason for the adjustments.
6. All claims that require reprocessing due to errors caused by the Contractor in processing or due to system design are not chargeable to claim volume accounting during each fiscal year and must be identified and deleted from all contract administrative reports.
7. No transaction shall be counted as a claim that does not meet the specific criteria stated above. Only claims adjudicated by the system for payment or denial shall be counted.

H.25 MODIFICATION TASK

H.25.1 The price for providing ongoing MMIS systems modification support, as defined in Subsection C.9, and including machine time, person time, and documentation, shall

be included in the fixed price offer for each contract operations period. As described in Subsection C.9.2, this task requires full-time, on-site support from:

1. A Modification Task Manager; and
2. Five (5) Systems Analysts, with a minimum of three years of MMIS development or ongoing maintenance and modification experience.

H.26 Modification Requests

From time to time, the Medical Assistance Administration will request maintenance activity or modifications to the MMIS to be performed by the Contractor. The District shall make any such request in writing signed by the COTR and plainly labeled or titled a "Change Request." The Change Request shall contain a clear distinction of whether the requested activity is a maintenance or a modification activity, a description of the required maintenance or modification activity, the requested implementation date, the latest possible implementation date and the priority.

H.26.1 The Contractor shall promptly, and in no event more than ten (10) business days after receipt of such Change Request, furnish to the COTR a written acknowledgment of the receipt of the Change Request which (a) confirms the requested due date, (b) proposes a different due date up to but not later than the latest possible implementation date stated on the Change Request, (c) includes a list of definitive questions that must be answered by the District before a due date is established, (d) denies that the request is a "maintenance" request but is instead an "enhancement" which is outside the scope of the contract requirements, or (e) states that the Change Request cannot be accomplished by even the latest possible implementation date because the work hours exceed the capacity of the resources available and that to accomplish the Order the Contractor is entitled to additional compensation and/or time consideration. If the acknowledgment is of the type described in provision (a) or (b) of this subsection, it should be accompanied by a list of appropriate Contractor personnel assigned to the Change Request and the estimated number of hours of each staff member assigned to the order.

H.26.2 If the written acknowledgment is of the type described in provision H.26.1 (2), (3), (4), or (5) above, the parties shall then negotiate and attempt in good faith to agree upon a plan and schedule for implementation of the Change Request with the personnel available. If the COTR agrees that the Change Request cannot be accomplished by the available personnel in the time allotted, the Contractor must, within five (5) business days, respond with a detailed proposal containing:

1. A statement of the scope of the Change Request in relationship to subsystems, functions, features and capabilities to be changed;
2. A breakdown of the work effort by Milestone;
3. A breakdown of the work effort by hour within each job classification required;

4. A rate per hour for each job classification required with a total proposed amount;
5. An implementation schedule for the Change Request and, if appropriate, revised schedules for all other concurrently approved projects/Change Requests effected by the Change Request; and
6. A justification for the additional staff, rates and schedules.

The COTR will not agree to compensate the Contractor for additional personnel relief without all necessary District and Federal approvals.

H.26.3 A Change Request is deemed to be successfully completed when: (a) it has been canceled by the COTR in writing; OR, (b) the Contractor has received a technical sign-off initially signed by an authorized Medical Assistance Administration representative(s) and cosigned by the COTR; AND (c) the maintenance activity or enhancement has run in production for thirty (30) calendar days or through a complete production cycle (whichever is longer); AND, (d) all documentation has been drafted, approved by the District and provided in final form.

H.26.4 If the parties are unable to reach an agreement as described in Subsection H.26.2, the COTR may make a determination that the Change Request is:

1. Within the scope of the contract requirements and included in the price for the MMIS Enhancement and Implementation Tasks;
2. Is a maintenance request or is an modification request; and/or
3. May be accomplished with the available staff by a particular implementation date without additional compensation and/or time consideration.

H.26.4.1 Upon such written instruction from the COTR, the Contractor shall proceed forthwith to implement the Change Request, subject to the Contractor's right to appeal the COTR's determination pursuant to Paragraph 14 of at the "Standard Contract Provisions."

H.26.4.2 In the event the COTR fails to make the above determination and instruct the Contractor in writing, the Contractor shall not be obligated to implement the Change Request or to be entitled to any fiscal, schedule or modification group effort compensation for providing the detailed proposals specified in Subsection H.26.2.

H.26.5 If the Contractor considers that any written or oral communication, including any order, direction, instruction, interpretation or determination, received from the MMIS COTR, the District or any agent or representative thereof, or that any other act or omission of the COTR, the District or any agent or representative thereof (an "Event") constitutes a Change Request but is not plainly identified, labeled or titled as such, the Contractor shall so advise the COTR in writing within ten (10) business days of such Event but no later than three (3) business days from the Contractor's identification or discovery of such Event and shall request the COTR's written confirmation thereof. Such notice to the COTR shall state:

1. The nature and pertinent circumstances of the communication, act or omission regarded as a Change Request by the Contractor;
2. The date of the communication, act or omission, and the identification of each individual involved in such communication, act or omission, listing his or her name and function;
3. The identification of any documents involved;
4. The substance of any oral communications;
5. the particular technical requirements or contract requirements regarded as changed; and
6. The direct and foreseeable consequential effect of the communication, act or omission regarded as a Change Request including the number of work hours required from the staff to accomplish the Change Request and the manner and sequence of performance or delivery of supplies or services, identifying which supplies or services are or will be affected.

H.26.5.1 The COTR will respond within ten (10) business days of receipt of the Contractor's notice as required above, either:

1. To countermand the action or communication regarded as an Event; or
2. To deny that the Event is a Change Request; or
3. To confirm that the Event is a Change Request by issuance of a written notice; or
4. If the information in the Contractor's notice is inadequate to permit a decision to be made, advise the Contractor as to what additional information is required and establish the date by which said information should be furnished.

H.26.5.2 If the Contractor complies with any order, direction, interpretation or determination, written or oral without providing the notice in accordance with this Section, the District shall not be liable for any increased price, delay in performance or contract nonconformance by the Contractor.

H.26.6 If the COTR denies that the Event constitutes a Change Request, the Contracting Officer shall issue a final decision to this effect within a reasonable period of time and the Contractor may proceed in accordance with Paragraph 17 of the "Standard Contract Provisions."

H.26.7 Except as herein provided, no order, statement, or conduct of the MMIS Contract Administrator, the Medical Assistance Administration or any agent or representative thereof, shall be treated as an Event under this Section.

H.26.8 Any Event by the Contractor under this Section must be asserted within thirty (30) calendar days from the date of receipt by the Contractor of the written or oral communication.

H.26.9 For the purpose of issuing Change Requests under this Contract, the term "MMIS COTR" shall not include any representative of the MMIS Contract Administrator, whether or not such representative is acting within the scope of his or her authority, except in those instances where the COTR has notified the Contractor in writing, citing the authority of this Section, that a specified individual has the authority to issue Change Requests, and a description of the exact scope and duration of the individual's authority.

H.27 TURNOVER TASK

The District will not make separate payments to the Contractor for the Turnover Task activities defined in Section C.10. Any anticipated costs should be included in the price offer for the last full year of operations under the contract on Pricing Schedule B.4.2.

To provide a Contractor incentive to fully support the Turnover of the District of Columbia MMIS, supporting files, and other documentation to the District or the successor Contractor, fifteen percent (15%) of the monthly contract operations payments for the last six (6) months of the contract will be retained until all Turnover responsibilities are completed.

H.28 DEDUCTIONS FROM PAYMENTS

H.28.1 The District may, following proper notification to the Contractor, deduct from any payments due the Contractor the calculated amount of recovery for any assessed consequential or liquidated damages, or annual adjustments in operations payments due to a lower-than-estimated claim volume or modification support.

H.28.2 The District shall perform a monthly claims processing quality control assessment to ensure MAA's Requirements for the accuracy of data entry input, edit/audit dispositions, and other claims adjudication-related decisions are met. If errors of any kind are found from these reviews that are attributable to the Contractor and which, in total, exceed three percent (3%) of the number of claims processed during that month, or if the total claims with errors have a dollar value exceeding one percent (1%) of the total program dollars paid out for that month, then one percent (1%) of the operations payment owed to the Contractor for that month shall be deducted by the District.

This deduction shall occur for all months in which the error rate found during monthly quality control assessment activity performed by MAA staff exceeds the number or dollar thresholds.

H.28.3 Any offsets assessed for overall quality control problems shall not affect the District's rights to determine actual consequential damages for duplicate payments or overpayments to providers.

H.29 PROHIBITION AGAINST ADVANCE PAYMENTS

No payment shall be made by the District in advance of, or in anticipation of, services actually performed and/or of supplies furnished under this contract. Monthly invoices shall be submitted for work performed the previous month. Specifically excluded from this provision are the procedures for payment and possible adjustment for claim volume changes during the Operations Task and the payment for the Turnover Task.

H.30 REIMBURSEMENT COSTS

H.30.1 The following subsection addresses the only item that shall be reimbursable to the Contractor monthly for the "actual" costs as defined in Section G.9.4.

H.30.2 All postage required for the distribution correspondence, policies, billing instructions, and forms relating to the operation of the MMIS shall be paid by the Contractor who shall be reimbursed monthly for its "actual" costs. The Contractor shall exert all reasonable efforts to employ any commercially available techniques such as bulk mailing, consolidation of mailing and zip code pre-sorting or the use of carriers other than the United States Postal Service to reduce any postage costs assumed by the Medical Assistance Administration. For the purpose of this section, "postage" shall include amounts charged by commercial carriers, except that the Contractor shall not employ the services of commercial carriers without the prior written approval of the COTR.

H.31 SUPPLIES

The Contractor shall acquire, store and disburse during the entire life of the Contract, at its expense all forms, paper, microfilm, microfiche, film, magnetic tapes, CD's, DVD's and other supplies necessary to document, record or transmit information or to perform its processing functions in connection with the successful MMIS design, development, testing, implementation, operation, maintenance, and modification.

H.32 RETURNED PROVIDER CHECKS

H.32.1 Throughout the Contract, the Contractor shall receive returned provider checks drawn on the District's account. For those returned due to incorrect or incomplete mailing address, within five (5) business days of receipt (or the Medical Assistance

Administration's forwarding) the Contractor shall research the correct address, re-mail the check, and notify the Medical Assistance Administration weekly in writing of all re-mailings.

H.32.2 All non-District provider checks, checks for which a better address cannot be reasonably found, and all other checks sent to it for any reason, shall be delivered to the Medical Assistance Administration within two (2) business days from the date of Contractor's receipt of such checks. Whenever possible, the Contractor shall record sufficient identifying information for each returned check to trace it back to the production cycle of its issuance, the reason for return, and the provider(s) making the return.

H.33 RECOUPMENT AND ERRONEOUS PAYMENTS

H.33.1 During the MMIS Operation Task, the Medical Assistance Administration may direct the Contractor to recoup amounts from sums payable to the provider. A recoupment shall consist of a negative adjustment to a previous payment(s). The Contractor shall not effect any recoupments except upon the prior written authorization of the COTR or his/her written designee.

H.33.2 An erroneous payment is such part or all of any payment made with respect to a claim that should not have been paid according to the then applicable criteria for payment of that claim when applied to the information provided by the Medical Assistance Administration prior to the processing of that claim. The Contractor shall be liable to the Medical Assistance Administration for all erroneous payments. Upon the Contractor's discovery of an erroneous payment, the Contractor shall notify the Medical Assistance Administration orally and in writing within twenty-four (24) hours of its discovery. All of the circumstances relating to the cause and the effect of each such error, including the identification of each provider affected, the amount of overpayment or underpayment made to the provider, and the identification of all affected claims, shall be furnished to the Medical Assistance Administration as quickly as possible but in any event no later than five (5) business days after discovery.

H.33.3 Upon its receipt of a written direction from the COTR ordering it to undertake a recoupment, the Contractor shall complete all steps necessary to implement the recoupment for all affected claims before the end of the next pay cycle occurring after its receipt of the direction. In the event that the volume of claims affected by the direction or the complexity of the recoupment task is so great as to make it impossible for the Contractor to fulfill the requirements of the preceding sentence, the Contractor shall notify the COTR in writing, within twenty-four (24) hours of its receipt of the direction, of the earliest time frame within which it can implement the recoupment. After consideration of the circumstances described by the Contractor, the COTR shall grant in writing whatever extension of time he or she deems necessary to implement the recoupment. The Contractor shall pay to the Medical Assistance Administration any portion of an erroneous payment not recouped within one hundred eighty (180) calendar days of its receipt of the direction initiating its recoupment. The Contractor

shall make such payment to the Medical Assistance Administration within seven (7) calendar days of the expiration of the one hundred eighty (180) calendar day period.

H.33.4 The District shall not be liable to the Contractor for any repayment amount due which is not recovered by recoupment from providers. The Contractor may only initiate independent recovery procedures and actions with the prior written approval of the COTR once the recoupment process described herein has been completed and a repayment amount remains outstanding. If the Medical Assistance Administration recovers any erroneous payments for which the Contractor has reimbursed the Medical Assistance Administration, the Medical Assistance Administration shall notify the Contractor who shall then submit a standard District invoice for the returned amount.

H.34 SUSPENSION OF WORK

H.34.1 At any time during the MMIS Enhancement and Implementation Task, the Contracting Officer may order the Contractor by written notice to suspend all or any part of the work for such period of time as the COTR may determine to be appropriate for the convenience of the Medical Assistance Administration.

H.34.2 If, without any fault or negligence of the Contractor, the performance of all or any part of the work under the contract is, for an unreasonable period of time, suspended, delayed, or interrupted by an act of the COTR or any other authorized person acting on behalf of the COTR, the District or any agent or representative thereof in the administration of the contract, or by their failure to act within the time specified in the contract (or if no time is specified, within a reasonable time), the COTR will make an adjustment for any increase in the cost of performance of the Contract or in the schedule necessarily caused by the unreasonable period of such suspension, delay, or interruption, subject to the Contractor's right to appeal the COTR's determination of the adjustment pursuant to Paragraph 14 of the "Standard Contract Provisions." No adjustment shall be made to the extent that performance by the Contractor would have been prevented by other causes if the work had not been so suspended, delayed or interrupted.

H.34.3 No claim for suspension, delay or interruption under the Contract under this Section shall be allowed for any costs incurred due to a lack of appropriation under paragraph 22, Appropriation of Funds, of the Standard Contract Provisions. No claim for suspension, delay or interruption under the Contract under this Section shall be allowed for any costs incurred more than twenty (20) calendar days before the Contractor shall have notified the COTR in writing of the act or failure to act involved (but this requirement shall not apply where a suspension order has been issued).

H.35 GUARANTEES, WARRANTIES, AND CERTIFICATIONS

The following subsections address guarantees, warranties, and certifications regarding the District of Columbia MMIS.

H.35.1 CONDITIONS ON APPROVAL OF CERTIFIED MMIS SYSTEM

The Contractor shall propose a fully certified MMIS system as described in Section C.1 hat satisfies all conditions classified by CMS certification guidelines which shall include the CMS certification approval letter. The Contractor shall satisfy all such conditions as a prerequisite to the satisfactory conclusion of the District of Columbia MMIS Enhancement and Implementation Task, Acceptance Test Subtask milestones. These conditions cannot be passed on to the District of Columbia MMIS in whole or in part.

H.35.2 MODIFICATIONS TO THE CERTIFIED MMIS SYSTEM

H.35.2.1 The Contractor will promptly but no later then fourteen (14) calendar days after initiation of installation notify the Medical Assistance Administration of all enhancements, abridgments and other modifications to the base system made by the Contractor in another/other state(s) which occur after the submission of the proposal. The notice shall include a description of the functional effect of the modification, and shall indicate whether, and to what extent, the modification was made for each of the following reasons:

1. To satisfy a CMS condition for certification;
2. To conform the system to a change in federal law or regulation which became applicable after certification; or
3. To effect a change requested to comply with a unique District requirement, or as an elective change.

H.35.2.2 If the Medical Assistance Administration desires the modification to be incorporated into the District of Columbia MMIS, it will proceed under Subsection H.25, "MODIFICATION TASK".

H.35.3 YEAR 2000 WARRANTY

The Contractor warrants that each hardware, software, and firmware product delivered under this contract and listed below shall be able to accurately process date data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, including leap year calculations, when used in accordance with the product documentation provided by the Contractor, provided that all listed product properly exchange date data with it. If the Contract requires that specific listed products must perform as a system in accordance with the foregoing warranty, then that warranty shall apply to those listed products as a system. The duration of this warranty and the remedies available to the Government for breach of this warranty shall be as defined in, and subject to, the terms and limitations of the Contractor's standard commercial warranty or warranties contained in this contract, provided that notwithstanding any provision to the contrary in such commercial warranty or warranties, the remedies available to the Government under this warranty shall include repair or replacement of any listed product whose non-compliance is discovered and make known to the Contractor in writing within ninety (90) days after acceptance. Nothing

in this warranty shall be construed to limit any rights or remedies the Government may otherwise have under this contract with respect to defects other than Year 2000 performance.

H.35.4 WARRANTY OF THE SYSTEM

Notwithstanding prior acceptance of deliverables by the District, the Contractor shall expressly warrant all delivered programs and documentation as properly functioning and compliant with the terms of the contract. The Contractor shall correct all errors and design deficiencies in the system and replace incorrect or defective programs and documentation within one (1) week of notification from the COTR of such deficiencies or within such period as may be necessary to make correction(s) using all due diligence and dispatch as agreed upon between MAA and the Contractor. If the Contractor fails to repair an identified error, deficiency, or defect within such period, the District may, at its sole discretion, act to repair, and the Contractor expressly agrees to reimburse the District for all costs incurred thereby. This warranty shall be in effect throughout the term of the contract and for three (3) months thereafter. Deficiencies properly noted before expiration of the warranty shall be covered regardless of such expiration. System modifications and other changes made during the contract period shall also be covered by this warranty.

H.35.5 SITE PREPARATION

No item of equipment shall be delivered or accepted unless and until the Contractor has determined and certified that the installation site for that item meets the site specifications furnished by the Contractor (and approved by the Distrct) and that no further site preparation is necessary. If additional site preparation is required, the Contractor shall reimburse the District for the cost thereof, if the additional cost is due to an error in Contractor specifications or certifications of that site.

H.35.6 DELIVERY AND INSTALLATION

H.35.6.1 The Contractor shall arrange for transportation, delivery, and installation of the equipment at the Medical Assistance Administration's location, subject to Subsection H.35.5, "SITE PREPARATION".

H.35.6.2 The equipment shall be delivered and made operational to the Medical Assistance Administration according to the approved Work Plan schedule. If the Contractor fails to make delivery within the agreed-upon period for reasons other than failure of the Medical Assistance Administration to meet site specifications, in addition to any other legal remedies the Medical Assistance Administration may have, the Medical Assistance Administration shall have the right to cancel its approval of the placement order at any time between the expiration of the applicable period and actual delivery. Otherwise, a placement order may be canceled, or delivery postponed, only once, by written notice given not less than thirty (30) days before the initially scheduled delivery date.

H.35.7 EQUIPMENT IDENTIFICATION

The District reserves the right, for inventory purposes only, to require the Contractor to affix a label to all rented, leased, or purchased equipment obtained from the Contractor under this Contract. The label will identify the equipment as "District of Columbia" and contain the manufacturer's serial number or the Medical Assistance Administration's internal property number. If affixed, the label will be removed by the Contractor at the expiration of the lease or rental term for leased or rented equipment.

H.35.8 ACCEPTANCE TEST

H.35.8.1 Except as provided hereinafter, no charges will accrue to the District for any leased, rented or purchased item of Equipment, Software or Feature ordered under this RFP until the item of Equipment, Software or Feature has passed an Acceptance Test as described in Section C.5.2. An item of Equipment, Software or a Feature shall be deemed to have passed the test once it has been delivered, installed at the site, and is operational based on the following definitions and conditions:

1. The Delivery Date is the date on which the user (Medical Assistance Administration) receives the Equipment, Software or Feature;
2. The Installation Date is the date on which the Contractor certifies that the item of Equipment, Software or the Feature is installed at the site and ready to operate pursuant to Contractor's installation policy;
3. The Acceptance Date is the date on which the Equipment, Software or Features has operated effectively for ninety (90) continuous days;
4. The Performance Period is the period between the Installation Date and the Acceptance Date;
5. For leased, rented or purchased Equipment, Software or Features, charges will be due and payable by the Medical Assistance Administration on the Acceptance Date; and
6. For purposes of determining the date as of which charges will be due and payable, any delay of installation or the start of the Performance Period not the responsibility of Contractor will reduce the required number of Performance Period days of consecutive operation on a one-for-one basis.

H.35.8.2 In the event an item of equipment, software or a feature does not pass the Acceptance Test during the initial performance period, the Acceptance Test shall recommence at a new installation date and continue until the required number of consecutive days is achieved. If an item of Equipment, Software or a Feature fails to pass the Acceptance Test after ninety (90) days from its Installation Date, the District may at its option request and receive a replacement, or accept the Equipment at its demonstrated level of performance. Such acceptance does not

release the Contractor from any other obligation under the contract, including, but not limited to, Subsection H.38, "LIQUIDATED DAMAGES". Acceptance test measurements are as follows:

1. The Acceptance Test Level for an item of equipment or a feature is computed by dividing Downtime (as defined below) for that item or feature by Operational Use Time, multiplying the result by one hundred (100), and subtracting that result from one hundred percent (100%).

2. Operational Use Time as defined herein shall be the number of hours the equipment, software or feature must be available to the Medical Assistance Administration in the ninety (90) day test period.

3. Downtime for an item of equipment, software or a feature is defined as Operational Use Time hours during which the item of Equipment, Software or Feature is inoperable because of causes other than those which are external to the Contractor's control. Downtime for each incident shall run from the time the Medical Assistance Administration contacts the Contractor's Project Manager (or designated representative) by telephone until access to the functionality is restored to the Medical Assistance Administration in proper operating condition.

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H.35.9 MAINTENANCE ACCEPTANCE

H.35.9.1 The Contractor shall be responsible for all maintenance of equipment and software related to this Contract, at no additional cost to the District above the prices proposed in Section B for the period of time the MMIS is operated.

H.35.9.2 The Contractor shall provide and maintain, as required in RFP Subsection C.9.2, a staff of systems professionals in the Maintenance and Operations Support Group. These individuals, and all of their required equipment, space, supplies and overhead, shall be provided to the District pursuant to this contract, at no additional cost to the District above the prices proposed in the Contractor's Price Proposal or the period of time the MMIS is operated.

H.35.10 RISK OF LOSS

H.35.10.1 The Contractor (and its insurers, if any) shall bear all risk of loss to the equipment or software, which occurs in transit to the Medical Assistance

Administration site. The risk of loss or damage to purchased equipment shall remain with the Contractor until the District has accepted the equipment.

H.35.10.2 The Contractor shall also bear the risk of loss or damage to leased or rented equipment during the District's use and possession thereof until the District exercises its purchase option and title has passed to the District.

H.35.10.3 In no event shall the Contractor be liable for loss or damage due to the negligence of the District, or for damage due to nuclear reaction, nuclear radiation or radioactive contamination arising out of the use by the Medical Assistance Administration of radioactive materials.

H.35.11 TITLE

H.35.11.1 Title to each item of equipment sold to the District under this contract shall remain with the Contractor until the entire purchase price (reduced by any judicially determined or agreed-upon set-offs or credits), has been paid by the Medical Assistance Administration. Title shall then pass to the District, and the Contractor shall then execute and deliver such instruments of transfer as the Medical Assistance Administration may reasonably require. All equipment purchase payments, under this contract, shall be scheduled for completion prior to the end of the Contract.

H.35.11.2 Title to each item of equipment leased or rented under this Contract shall remain in the Contractor's name until the purchase option has been exercised and the option price is paid. Thereupon, title shall pass to the District, and the Contractor shall then execute and deliver such instruments of transfer as the District may reasonably require.

H.35.11.3 Title to any accessories furnished by the Contractor shall follow title to the machines to which they relate.

H.35.12 WARRANTIES

H.35.12.1 With respect to all equipment to be delivered hereunder, the Contractor represents and warrants as follows.

1. All equipment delivered for purchase hereunder shall be new. "New" means unused since its manufacture, but new equipment may contain some components that are not new. In the case of leased equipment, the Contractor may provide re-manufactured or reconditioned equipment, if that fact is disclosed before the lease obligation is undertaken by the District, and if the equipment is warranted to operate as new.
2. The District's use and possession of any equipment delivered hereunder will not be interrupted or disturbed by the Contractor or by any person claiming by, under or through the Contractor, provided the District is not in default of any payments due for that equipment or otherwise in breach of this contract.

None of the equipment shall be subject to any lien, claim, or other encumbrance, which is inconsistent with this warranty.

3. All equipment delivered hereunder shall operate in accordance with the physical, performance and other specifications and representations applicable under this Contract.
4. For a period of time commencing on the Acceptance Date and expiring with the term of the contract, with respect to all equipment delivered hereunder, the Contractor agrees to repair or replace, as is necessary, any equipment or part thereof which ceases to operate, in accordance with this Contract's terms and conditions; technical specifications; or acceptance criteria. Such repair or replacement shall be performed by the Contractor at no charge to the District for such costs related to the repair as labor, replacement parts, shipping (either of the replacement parts to the District or the defective part back to the Contractor), delivery, installation, or any other cost incurred in the repair. Said repair or replacement pursuant to this clause must be at least as good, in terms of response and total repair time, as the District would have received under the Contractor's standard maintenance contract.

H.35.12.2 The warranties in this Section do not replace or diminish any warranties contained in the Contractor form portion (if any) of this contract, but are in addition thereto.

H.35.12.3 The Contractor shall not be liable under this Section for the failure of any equipment furnished by the Contractor under this contract due to the use of an attachment, feature or device that was supplied by a different manufacturer and was not approved in writing by the Contractor. The approval of the use of any such attachment, feature or device shall not be deemed a representation, warranty or understanding by the Contractor regarding the modification, including its performance in conjunction with the Contractor's equipment.

H.35.13 MOST FAVORED CUSTOMER

H.35.13.1 During the life of this Contract all prices or rates charged by the Contractor shall be computed using the lower of:

1. The Contractor's proposed Pricing Schedules or rates; or

2. The lowest price or rate charged by the Contractor, for the same or lower volume, under any contract entered into with any of its customers.

H.35.13.2 This provision shall not apply to:

1. Sales made by the Contractor for resale;
2. Sales to educational institutions;
3. Transfers which are deemed to be charitable contributions;
4. Sales to customers other than the District which orders include substantial software and/or services when the District orders include hardware equipment only;

5. Sales to customers under contracts by which the customer guarantees to purchase a specific minimum volume of goods and/or services or commits to a minimum dollar value of purchases and under which the customer, if it fails to acquire the required volume of goods and/or services or minimum dollar amount, pays no less for the goods and/or services actually acquired than the District would pay for the same goods and/or services;
6. sales made under discount provisions which accord a more favorable discount for purchases made in bulk shipment quantities, where the District purchases are not made in the bulk shipment quantities which establish the more favorable discount; or
7. Sales made under contracts whose duration is significantly shorter than the contract period specified by the District. If the duration differs from the District's requirements by twelve percent (12%) or more, it shall be considered to be significantly different duration to make this clause effective.

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H.35.14 INFRINGEMENT PROTECTION

H.35.14.1 The Contractor represents to the best of its knowledge neither the equipment nor software provided pursuant to this Contract, nor the use thereof, violates or infringes upon any patent, copyright, or any other right of a third party. In the event of any action brought against the District in which infringement of a US patent or copyright is claimed, the Contractor will defend or settle the claim at its own expense, and indemnify the District against any expenses, costs or damages incurred by the District on account of such claim, but such defense, settlement and payment are conditioned on the following:

1. the Contractor is notified of any claim promptly after the District becomes aware of it; and
2. the District gives the Contractor information reasonably available and assistance reasonably necessary to facilitate the settlement or defense of such claim and, to the extent permitted by law, the District makes any defenses available to it available to the Contractor.

H.35.14.2 In such event, the Contractor shall have the right to disapprove any negotiated settlement.

H.35.14.3 In the event such a claim occurs or in the Contractor's opinion is likely to occur, the Contractor will, at its option and expense, either procure for the District the right to continue using the equipment and software, or replace or modify the same so that they become non-infringing. If, despite the reasonable efforts of the Contractor, neither alternative is feasible, the Contractor will accept return of the infringing products, without charge or penalty for premature termination of any lease or rental. If such products

were purchased or licensed in perpetuity, the Contractor will grant the District a credit equal to the price paid by the District reduced by depreciation to the date of return calculated by straight line method over an assumed five-year (5) life with no residual value.

H.35.14.4 The Contractor shall not indemnify the District against any claim of infringement arising out of equipment, software or modifications, not supplied by the Contractor. No limitation of liability provision of this Contract shall apply to the indemnification provided by this Section.

H.35.15 PATENT OR COPYRIGHT INFRINGEMENT

H.35.15.1 The Contractor represents that, to the best of its knowledge, none of the software to be used, developed, or provided pursuant to this contract violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against MAA or the District for the infringement of such patents or copyrights arising from the Contractor's or the District's use of any equipment, materials, computer software and products, or information prepared for, or developed in connection with performance of, this contract, then the Contractor shall, at its expense, defend such use. The Contractor shall satisfy any final award for such infringement, whether it is resolved by settlement or judgment involving such a claim or suit.

H.35.15.2 The District shall give the Contractor prompt written notice of such claim or suit and full right and opportunity to conduct the defense thereof, together with full information and all reasonable cooperation. If principles of governmental or public law are involved, the District may participate in the defense of any such action. No Contractor costs or expenses shall be incurred by the District without the Contractor's written consent.

H.35.15.3 If, in the Contractor's opinion, equipment, materials, software, and products or information used in this contract are likely to or do become the subject of a claim of infringement of a United States patent or copyright, then without diminishing the Contractor's obligation to satisfy any final award, the Contractor may, with the District's consent, substitute other equally suitable equipment, materials, and information, or at the Contractor's option and expense, obtain the right for the District to continue the use of such equipment, materials, and information. In the event of equipment and/or software substitution, the District must protect its interests in data used by such equipment or software through recovery or conversion of such data to other approved equipment or software. The Contractor shall, in any such suit, satisfy any damages for infringement assessed against the District or its departments, officers, employees, or agents resulting from said lawsuit, whether it is resolved by settlement or judgment.

H.36 PERSONNEL

The following subsections detail provisions regarding Contractor and District personnel.

H.36.1 EMPLOYMENT OF DISTRICT PERSONNEL

The Contractor shall not knowingly engage on a full-time, part-time, or other basis, during the period of the contract, any professional or technical personnel who are, or have been at any time during the period of this contract, District of Columbia employees except those regularly retired individuals, without prior written approval from the District. Recently retired (within one year) employees of DOH shall not knowingly be engaged for performance of this contract on a full-time, part-time, or other basis, without prior written approval from the District.

H.36.2 INDEPENDENT CAPACITY OF CONTRACTOR PERSONNEL

It is expressly agreed that the Contractor or any subcontractor involved in the performance of this contract shall act in an independent capacity and not as an agent, officer, employee, partner, or associate of the District. Contractor staff will not hold themselves out as, nor claim to be officers or employees of the District of Columbia by reason hereto. It is further expressly agreed that this contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and the District.

H.36.3 KEY PERSONNEL

H.36.3.1 The services of each named individual shall be required unless that individual becomes unavailable to the Contractor only for reasons such as the individual's death, disability, or termination of the underlying employment relationship.

H.36.3.2 If an individual named in this subsection becomes unavailable for such reasons, the Contractor within ten (10) business days of said individual's notice shall give the COTR the resume of a proposed replacement, and offer the Medical COTR an opportunity to interview that person. If the Contracting Officer is not reasonably satisfied that the proposed replacement has comparable ability and experience, he shall so notify the Contractor within ten (10) business days after receiving the resume and completing any interview, whereupon the Contractor shall propose another replacement and the COTR shall have the same right of approval. Such process shall be repeated until a proposed replacement shall be approved by the COTR. If after thirty (30) days from said individual's notice, a qualified replacement is not approved, damages may be imposed by the Contracting Officer.

H.36.3.3 The Contracting Officer shall have the right to require the Contractor to remove any individual (whether or not named in this subsection) from his assignment to this Contract by the Contractor or any subcontractor, but only for cause and upon reasonable notice.

H.36.3.4 Key personnel title for the Enhancement and Implementation Task are:

a) Project Manager/Account Manager,
b) Implementation Task Manager,
c) Conversion Task Manager, and
d) Implementation/Claims Processing Manager.

H.36.3.5 Key personnel for the Operations and Modifications Task are:

a) Project Manager/Account Manager,
b) Operations/Claims Processing Manager,
c) Modifications Task Manager/System Analysts, and
d) Provider Relations Manager.

H.36.3.6 Temporary or permanent transfer of any of the above named Key Contractor Personnel within the District of Columbia MMIS Project or temporary or permanent transfer of any of the above named Key Contractor Personnel between Contractor Projects shall require prior written approval of the Contracting Officer, which shall not be unreasonably withheld.

H.36.4 TERMINATION OF KEY PERSONNEL

H.36.4.1 The COTR shall monitor the Contractor' s efforts and account for all work to be performed by Contractor personnel. He/she shall determine whether Contractor key personnel are performing satisfactorily at the appropriate skill levels specified in the RFP, the Contractor' s Proposal, and the approved Work Plan.

H.36.4.2 The Contractor shall not alter the numbers and distribution of MMIS staff as offered in its proposal without the prior written approval of the Contracting Officer, which shall not be unreasonably withheld.

H.36.4.3 The Contracting Officer may require the Contractor to relieve any of the ersonnel (as defined in H.36.4, KEY PERSONNEL, above) from any further work under this Contract if in his/her sole opinion:

1) The individual does not perform at the applicable skill level specified in the RFP, the Contractor' s proposal, and the approved Work Plan;
2) The individual does not deliver work which conforms to the performance standards stated in the RFP, the Contractor' s proposal, and the approved Work Plan; or

3) Personality conflicts with Medical Assistance Administration personnel hinder effective progress on the work of the project or unit to which the individual is assigned.

H.36.4.4 The Project Manager shall immediately notify the COTR of the resignation or discharge of any Contractor Key Personnel assigned to this Contract, and such personnel shall be forthwith relieved of any further work under this Contract.

H.36.5 REPLACEMENT OF TERMINATED KEY PERSONNEL

If the Contracting Officer notifies the Contractor that a replacement is required for a Contractor employee whose position is defined as Key Personnel in paragraph H.36.3, above, and who has been relieved from work under this Contract, the Project Manager shall deliver to the COTR resumes of at least two (2) candidates for each position specified in the notice, within five (5) business days after receipt of notice. Within three (3) business days after receipt of the resumes of proposed replacement candidates, the COTR shall contact the Project Manager to state which, if any, of the proposed candidates have been rejected upon review of their resumes, and they shall schedule interviews with the others. The COTR may reject any candidate for whom the Project Manager is unable to schedule an interview within three (3) business days following the contact, and may reject any candidate following his interview. If the COTR requires it, the Project Manager shall submit resumes of an additional replacement candidate for each rejected candidate. The COTR shall complete the selection of candidates within two (2) business days after the final candidate interview. Upon completion of candidate selection by the Contracting Officer, the COTR and the Project Manager shall schedule the start dates of the selected candidates, which shall not be later than ten (10) business days after the selection. The above time frames shall be adhered to unless a longer period of time is agreed to by both parties and approved by the Contracting Officer.

H.37 CONSEQUENTIAL DAMAGES - FAILURE TO MEET CONTRACT REQUIREMENTS

It is expressly agreed by the District and the Contractor that, in the event of a failure to meet the following performance requirements, the corresponding consequential damages shall be sustained by the District, and the Contractor shall pay to the District its actual damages as follows:

H.37.1 SYSTEM CERTIFICATION REQUIREMENTS

H.37.1.1 Section 1903(a)(b)(d) of Title XIX provides seventy-five percent (75%) Federal financial participation (FFP) for operation of mechanized claims payment and information retrieval systems approved by CMS. Up to ninety percent (90%) FFP is available for MMIS-related development costs prior approved by CMS in the District's APD and at contract

signing. The planned District of Columbia MMIS must, throughout the contract period, meet all certification and recertification requirements established by CMS.

H.37.1.2 The Contractor shall ensure that Federal certification approval for the maximum allowable enhanced FFP for the planned District of Columbia MMIS is obtained retroactive to the day the system becomes operational and is maintained throughout the term of the contract. Should decertification of the MMIS, or any component part of it, occur prior to contract termination or the ending date of any subsequent contract extension, the Contractor shall be liable for resulting damages.

H.37.1.3 The Contractor shall quickly and at its own expense remedy any defects or deficiencies found that prohibit, delay, or limit full federal MMIS certification. The Contractor shall make all such remedies within thirty days (30) of their discovery, whether they are discovered before or after implementation. Correction of defects or deficiencies shall not automatically reduce or negate liquidated damages related to failure to achieve complete and timely certification.

H.37.2 SYSTEM CERTIFICATION – DAMAGES

H.37.2.1 The Contractor shall be liable for the difference between the maximum allowable enhanced Federal financial participation and that actually received by MAA, including any losses due to loss of certification, failure to obtain approval retroactive to day one (1), delays in readiness to support certification.

H.37.2.2 All FFP liquidated damages claims assessed by CMS shall be withheld from moneys payable to the Contractor until all such damages are satisfied. Damage assessments shall not be made by the District until CMS has completed its certification approval process and notified the District of its decision in writing.

H.37.3 CONSEQUENTIAL DAMAGES FOR DISTRICT SANCTIONS

In addition to the indemnification clause, if during either MMIS Enhancement and Implementation or Operations Tasks, CMS imposes fiscal sanctions against the District as a result of the Contractor's or any subcontractor's action or inaction, the Contractor shall compensate the Medical Assistance Administration the amount lost by the District by application of the sanctions.

H.37.4 CORRECTNESS OF PAYMENTS - PERFORMANCE REQUIREMENT

H.37.4.1 The Contractor shall make all payments, adjustments, and other financial transactions made through the MMIS on behalf of eligible clients (as identified by the ACEDS interface), to enrolled providers, for approved services, and in accordance with the payment rules and other policies of the District of Columbia.

H.37.4.2 The Contractor shall be liable for the actual amount of any erroneous payments, overpayments or duplicate payments identified as a result of District or Federal claims reviews or as reported by providers or from other referrals, which are a result of incorrect Contractor staff action or inaccurate system data and processing. Such liabilities will be withheld from Contractor payments. However, the Contractor may seek recovery, on behalf of the District, from providers to whom erroneous payments are made, utilizing voluntary refund, offset recovery, or other District-approved methods.

H.37.4.3 The Contractor shall notify the District immediately upon discovery of any erroneous payments, overpayments or duplicate payments, irrespective of cause, and prior to initiating appropriate recovery action. The Contractor shall notify the District, using the change request process, of any system errors that result in a potential provider overpayment.

H.37.5 CORRECTNESS OF PAYMENTS – DAMAGES

The Contractor shall be liable for the erroneous payment, overpayment or duplicate payment for which full recovery cannot be made by the Contractor, using all reasonable procedures, if the erroneous payment, overpayment or duplicate payment is made to a provider and that payment is the result of failure of the Contractor to either utilize available information or to process correctly. The Contractor shall notify the District immediately upon discovery of any erroneous payments, overpayments or duplicate payments, irrespective of cause.

H.37.6 OPERATIONAL START DATE - PERFORMANCE REQUIREMENTS

H.37.6.1 The District intends to have the planned District of Columbia MMIS fully operational on February 28, 2008 as set forth in Section C.1.11.1 (5) of this RFP. On or before February 28, 2008, the Contractor shall provide a fully operational system that can begin processing correctly all claim types, claims adjustments, and other financial transactions; maintaining all system files; producing all required reports; and performing all other Contractor responsibilities specified in as set forth in Section C.7.20 of this RFP for the new MMIS. The Contractor shall provide a system with all enhancements approved by the District.

H.37.6.2 Compliance with the February 28, 2008, date is critical to the District's interest. Therefore, the Contractor shall be liable for resulting damages stated in Section H.37.7 if this date is not met. The District shall determine the

Contractor's capability to meet this date following the conclusion of the operational readiness test as set forth in Section C.7.20 of this RFP.

H.37.7 OPERATIONAL START DATE – DAMAGES

The District shall be held harmless for any losses, including financial, if the Contractor does not fully meet the operational start date as set forth in Section C.7.20 of this RFP with a new District approved MMIS as specified in the approved Detailed Work Plan. The District reserves the right to determine if the system is operationally ready. The Contractor shall be liable for damages which includes all costs incurred by the District to continue the current MMIS and Contractor operations. The Contractor shall also forfeit all claims for payment of monthly expenses and operational payments for that month and each month thereafter until the District approves operational readiness. In case of a partial month of non-implementation, a prorated amount shall be deducted from the monthly invoice.

H.37.8 CURE

In addition to the default clauses, if in the reasonable judgment of the District, a default by the Contractor is not so substantial as to require termination, reasonable efforts to induce the Contractor to cure the default are unavailing, and the default is capable of being cured by the District or by another resource without unduly interfering with continued performance by the Contractor, the District may provide or procure the services reasonably necessary to cure the default, in which event the Contractor shall reimburse the District for the reasonable cost of the services. In addition, the Contractor must cooperate with these resources in allowing access to the computer facility, documentation, software, utilities and equipment. The Contractor shall remain liable for all system performance criteria, maintenance of and further enhancements to any applications developed by these resources to the extent that it constitutes the Contractor's work product whether impacted by the work of the other resource or not.

H.38 LIQUIDATED DAMAGES - FAILURE TO MEET PERFORMANCE REQUIREMENTS

H.38.1 It is agreed by the District and the Contractor that, in the event of a failure to meet the performance requirements as set forth in Section H.38.2, the District shall sustain damage, and that it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the District will sustain in the event of, and by reason of, such failure; and it is therefore agreed that the Contractor will pay the District for such failures at the sole discretion of the District.

H.38.1.2 Damage assessments are linked to performance of system implementation or operational responsibilities.

H.38.1.3 The District will give written notification of each failure to meet a performance requirement to the Contractor. The Contractor shall have five (5) working

days from the date of receipt of written notification of a failure to perform to specifications to cure the failure. The District shall have the option to allow the Contractor additional days to cure the failure. If the Contractor does not resolve the failure within this warning/cure time period, the District may impose liquidated damages retroactively to the date of failure to perform. The District's imposition of liquidated damages is not in lieu of any other remedy available to the District.

H.38.1.4 If the District elects to not exercise a damage clause in a particular instance, this decision shall not be construed as a waiver of the District's right to pursue future assessment of that performance requirement and associated damages.

H.38.2 PERFORMANCE REQUIREMENTS FOR SYSTEM IMPLEMENTATION

The following are performance requirements damage clauses related to satisfactory completion of Enhancement and Implementation Task activities defined in Section C.7.5 and Section C.4:

a) Key dates, and

b) Key personnel.

H.38.2.1 Key Dates - Performance Requirement

H.38.2.1.1 The District intends to have the new MMIS developed, tested, and installed by February 8, 2008. Accomplishment of certain specified development activities by the key dates, as defined in Subsection C.7.5, and established in the detailed work plan is necessary to ensure full compliance with that start date.

H.38.2.1.2 If, for any reason, the Contractor is delayed in meeting these key dates and a contract modification to the work plan is not approved, the District may assess damages. Approval of contract modification or work plan modification does not summarily imply that the District will not assess damages to the Contractor.

H.38.2.2 Key Dates - Damages

The District may assess five hundred dollars ($500.00) damages per work day, or any part thereof, for each of the first ten (10) calendar days of delay in meeting a key date. The District may assess one thousand dollars ($1,000.00) damages per work day, or any part thereof, for each of the next thirty (30) calendar days of delay, up to two thousand dollars ($2,000.00) damages per work day, or any part thereof, for each additional day of delay after that. These damages shall be in addition to any amounts assessed for delays in obtaining Federal certification as set forth in Section H.37.1 through H.37.2. and/or meeting the operational start date as set forth in Section H.37.6.

H.38.2.3 Key Personnel - Performance Requirement

H.38.2.3.1 The Contractor shall not change personnel commitments provided in the Contractor's proposal for the Enhancement and Implementation Task activities without prior written approval of the COTR, unless due to the resignation or death of any named individual as set forth in Section C.4 and H.36.3. The Contractor shall include staffing for the following positions at the levels of effort proposed or as specified in the RFP:

a) Project/Account Manager,

b) Implementation/Claims Processing Manager,

c) Implementation Task Manager, and

d) Conversion Task Manager.

H.38.2.3.2 The Contractor shall not change personnel commitments provided in the Contractor's proposal for the Operations Task activities without prior written approval of the COTR, unless due to the resignation or death of any named individual. The Contractor shall include staffing for the following positions at the levels of effort proposed or as specified in the RFP:

a) Project/Account Manager,

b) Operations/Claims Processing Manager,

c) Modifications Task Manager, and

d) Provider Relations Manager.

H.38.2.3.3 The District shall approve in advance, in writing, any permanent or temporary changes to or deletion from the Contractor's named management, supervisory, and key professional personnel.

H.38.2.4 Key Personnel - Damages

The District may asses a maximum of five thousand dollars ($5,000.00) damages per occurrence for each key person proposed who is changed for reasons other than death or resignation or termination or military recall and an additional two hundred dollars ($200.00) per work day damages may be assessed for each work day after the initial thirty (30) calendar days allowed in Subsection H.36.4 that an acceptable replacement for that position is not provided.

H.39 PERFORMANCE REQUIREMENTS FOR OPERATIONAL RESPONSIBILITIES

The following are performance requirements and damages related to critical Contractor responsibilities during MMIS operations. Requirements and damages are defined for the following performance criteria:

a) Timeliness of claims processing,

b) System availability and response time,

c) Minimum file update processing cycles,

d) Timeliness and accuracy of report production,

e) EVS file update processes,

f) Recipient eligibility verification system availability,

g) System maintenance and modification,

h) Disaster Recovery and Recovery Testing,

i) Compliance with other material contract provisions.

H.39.1 Timeliness of Claims Processing - Performance Requirement

H.39.1.1 The Contractor shall meet the following claims processing timeliness standards.

a) The Contractor shall adjudicate ninety percent (90%) of all clean claims for payment or denial within thirty (30) days of receipt in the Contractor's mailroom.

b) The Contractor shall adjudicate ninety-nine percent (99%) of all clean claims for payment or denial within ninety (90) days of receipt in the Contractor's mailroom.

c) The Contractor shall adjudicate non-clean claims within 30 days of the date of correction of the condition that caused the claim to be unclean.

d) The Contractor shall adjudicate all claims within 12 months of receipt in the Contractor's mailroom, except for those exempted

from this requirement by federal timely claims processing regulations.

e) The Contractor shall process all nursing home claims in the next daily cycle after receipt.

f) The Contractor shall process all provider-initiated adjustments to payment or denial within forty-five (45) days of receipt in the Contractor's mailroom.

H.39.1.2 For purposes of this performance requirement the CMS State Medicaid Manual, Part 11 definition of a "clean claim" shall apply.

H.39.1.3 Those circumstances when claim resolution is being handled directly by District staff in accordance with District guidelines or held by the Contractor under District written directive shall not be counted in the days threshold.

H.39.2 Timeliness of Claims Processing - Damages

The District may assess ten thousand dollars ($10,000.00) for the first month of each failure to meet the above requirements. The District may assess twenty thousand dollars ($20,000.00) for each consecutive subsequent month a requirement remains unmet. For example, failure to meet the above requirements for four (4) consecutive months may result in the District's assessing damages in the amount of seventy thousand dollars ($70,000.00).

H.39.3 System Availability and Response Time - Performance Requirement

H.39.3.1 Where on-line access to the system is specified, the Contractor shall ensure that the average response time is no greater than the requirements set forth in Subsection C.3.3.2, at least ninety eight percent (98%) of the available production time between 7:00 a.m. and 6:30 p.m., Eastern Time, Monday through Friday, including District holidays for workstations. Average response time per terminal per available production hour per day shall be reported weekly. Response time is defined in Subsection C.3.3.1.

H.39.3.2 The Contractor must ensure that on-line access to all MMIS applications is available for all District users between the hours of 7:00 a.m. to 6:30 p.m., Eastern Time, Monday through Friday. An application is considered unavailable when a user does not get the complete, correct full-screen response to an input transaction within ten (10) seconds after depressing the "Enter" or other function key. The District will notify the Contractor when it has been determined that the system is unavailable. The Contractor will provide monthly reports showing system availability and unavailability by number of minutes per hour of the day. Cumulative system downtime must not exceed five (5) hours per terminal during any continuous five (5) day period.

H.39.3.3 The Contractor shall provide access to the on-line system during off hours and on weekends at no extra charge whenever requested by MAA at least forty-eight (48) hours in advance.

H.39.3.4 Performance requirements for the eligibility verification system data are in Subsection H.39.10.

H.39.4 System Availability and Response Time - Damages

The District may assess liquidated damages in the amount of one hundred dollars ($100.00) per week for each terminal down in excess of five (5) hours during a continuous five (5) day period. The District may assess liquidated damages in the amount of one hundred dollars ($100.00) damages per week for each week that the response time report demonstrates that the average response time per terminal per hour per day is greater than the specified time. Each terminal must be available ninety percent (90%) of the available production hours in a week.

H.39.5 Minimum File Update Processing Cycles - Performance Requirement

H.39.5.1 The Contractor shall provide the following minimum number of file update and claims processing cycles under this contract:

a) One (1) edit/pricing cycles per week,

b) One (1) audit (history) cycles per week,

c) One (1) weekly payment cycle per week,

d) Daily updating as specified in Subsection C.6.1 of the Recipient Master File with IMA data,

e) On-line, real-time entry of data of the Provider and designated Reference Files with nightly processing of updates,

f) Tape update pricing changes to the drug file at least twice monthly, and

g) Adjustments and recoupments keyed in for automated processing within ten (10) days of receipt.

H.39.5.2 The District will review these requirements for the quality of the data input and data entry keying accuracy standards of ninety-seven percent (97%).

H.39.5.3 Unless otherwise specified in Section C, each file update process must be completed and the file available on-line by 7:00 a.m. on the day following scheduled update and maintenance.

H.39.6 Minimum File Update Processing Cycles - Damages

The District may assess two hundred fifty dollars ($250.00) per hour damages for each hour of delay in completing the file update process for system master files by 7:00 a.m. each day. The District may claim assess five thousand dollars ($5,000.00) per incident as damages for any weekly payment cycle or daily adjudication cycle that is not

completed by 7:00 a.m. of the next day after its scheduled processing, unless prior written approval is authorized by the District.

H.39.7 Timeliness and Accuracy of Report Production - Performance Requirement

H.39.7.1 The Contractor shall produce MMIS reports in the format and type of media approved by the District. The Contractor shall be responsible for the accuracy of all reports, including calculations and completeness of data used as input. The District shall notify the Contractor, in writing, of any inaccuracies or discrepancies.

H.39.7.2 The Contractor shall deliver each MMIS report to the personnel and the location specified by MAA. The District will define report distribution list, including delivery location, number of copies, and media during the Enhancement and Implementation Task. The Contractor shall be required to update and maintain the report distribution list during the Operations Task to incorporate any changes to existing reports at no additional cost to MAA.

H.39.7.3 At a minimum, the Contractor shall be required to furnish reports on the following schedule:

a) Daily reports by noon of the following work day;

b) Weekly reports and cycle processing reports by noon of the next working day after the scheduled run;

c) Monthly reports by noon of the fifth working day after the end of the month;

d) Quarterly reports by noon of the fifth day after the end of the quarter;

e) Annual reports by noon of the tenth working day following the end of the year (whether Federal fiscal year, District fiscal year, waiver year, or other annual period); and

f) Ad-hoc and on-request reports on the date specified in the report request.

H.39.8 Timeliness and Accuracy of Report Production - Damages

H.39.8.1 The District may assess fifty dollars ($50.00) damages for each work day that any MMIS report is delivered to the correct location five (5) days after the date when it is due, or includes less than the required number of copies, or is not in the approved media.

H.39.8.2 If a report is not corrected within fifteen (15) days of the District's notice of failure to meet the reporting accuracy requirements, then the District may assess fifty dollars ($50.00) per day damages for each report that has been identified as inaccurate from the date of the notification until the date the corrected report is delivered.

H.39.9 MMIS Eligibility File Update Processes

H.39.9.1 The District may assess liquidated damages as set forth in the following payment reduction factor for failure to complete any scheduled MMIS Eligibility File update processes within the time frames established by the Contractor's response to Subsection C.6.1.2.2, C.8.1.2, and C.8.1.3. The following schedule will be used to assess liquidated damages which shall result in payment reduction, and which shall be cumulative:

a) Exceed the allotted time frame by less than 24 hours; one thousand dollars ($1,000) for every increment of 12 hours or portion thereof; and

b) Exceed the allotted time frame by more than 24 hours; two thousand dollars ($2,000) for each 12 hour period or portion thereof in excess of 24 hours.

H.39.9.2 The Contractor's performance shall be measured by the appropriate production reports and by direct inquiries from the Medical Assistance Administration.

H.39.9.3 Payment of any liquidated damages will not relieve the Contractor from its obligation to meet the requirements established by the Contractor's response to the RFP in regards to the MMIS Eligibility File update processes.

H.39.10 Recipient Eligibility Verification System Availability - Performance Requirement

The Contractor shall create a recipient extract file nightly after the Recipient Master File has been updated. This file shall be electronically transmitted to the EVS Contractor prior to 7:00 a.m. each production day.

H.39.11 Recipient Eligibility Verification System Availability - Damages

The District may assess five hundred dollars ($500.00) per day for a verified period of time when the updated EVS data file was not made available to the EVS Contractor by 7:00 a.m.

H.39.12 System Maintenance and Modification - Performance Requirement

The Contractor shall provide routine maintenance of the system at no charge to the District and not through use of the change control process. The Contractor must respond in writing to notices of system problems and Change Requests issued by the District within five (5) working days of receipt. Within fifteen (15) working days, the correction

must be made or a Requirements Analysis and Specifications document is due. The Contractor must correct the deficiency by an effective date to be mutually agreed upon between both parties. The Contractor shall perform all system modifications in accordance with an agreed-upon schedule.

H.39.13 System Maintenance and Modification - Damages

H.39.13.1 The Contractor shall assess liquidated damages as set forth in the following payment reduction factor the Contractor for failure to meet the functions associated with the Change Request process as established by the Contractor's response to RFP Subsections C.9.3 and specified in H.3.4.1. The District shall use the following schedules to assess liquidated damages and shall be cumulative unless otherwise indicated:

H.39.13.1.1 Failure to correct a system problem or complete a Change Request within the agreed upon completion date, where failure to complete was not due to the action or inaction on the part of the District as documented in writing by the Contractor:

> 1 < 30 calendar days late, two hundred fifty dollars ($250) per calendar day;

> 30 < 60 calendar days late, five hundred dollars ($500) per calendar day; and

> 60 calendar days late, one thousand ($1,000) dollars per calendar day.

H.39.13.2 The Contractor's performance shall be measured by the MMIS administrative and Change Request reports and by direct measurement by the Medical Assistance Administration.

H.39.13.3 Payment of any liquidated damages shall not relieve the Contractor from its obligation to meet the requirements established by the Contractor's response to the RFP in regard to the MMIS Modification Task.

H.39.14 Disaster Recovery and Periodic Testing

H.39.14.1 The District will assess liquidated damages as set forth in the following payment reduction factor to the Contractor for not testing and, if and when needed, implementing its disaster recovery plan within the allotted time frames established by the Contractor's response to RFP Subsection C.3.1.4 and C.7.2.4.6. The following schedule will be used to assess liquidated damages:

a) Implementation of the disaster recovery plan exceeds the proposed time by < 2 calendar days, five thousand dollars ($5,000);

b) Implementation of the disaster recovery plan exceeds the proposed time by > 2 < 5 calendar days, ten thousand dollars ($10,000);

c) Implementation of the disaster recovery plan exceeds the proposed time by > 5 < 10 calendar days, twenty-five thousand dollars ($25,000);

d) Implementation of the disaster recovery plan exceeds the proposed time by > 10 < 21 calendar days, fifty thousand dollars ($50,000); and

e) Implementation of the disaster recovery plan exceeds the proposed time by > 21 calendar days, one hundred thousand dollars ($100,000).

H.39.14.2 The District will measure the Contractor's performance by the ability of the backup facility or facilities to perform 100 percent of the appropriate MMIS functions as measured by the District's personnel.

H.39.14.3 Payment of any liquidated damages will not relieve the Contractor from its obligation to meet the requirements established by the Contractor's response to the RFP in regard to disaster recovery.

H.40 COMPLIANCE WITH OTHER MATERIAL CONTRACT PROVISIONS - PERFORMANCE REQUIREMENTS

H.40.1 The objective of this standard is to provide the District with an administrative procedure to address general contract compliance issues that are not specifically defined as performance requirements listed above, but are Contractor responsibilities contained in Subsections C.3.5 through C.3.8 of this RFP.

H.40.1 The District's staff may identify contract compliance issues resulting from the Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the District will notify the Contractor in writing of the nature of the performance issue. The District will also designate a period of time in which the Contractor shall provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the Contractor should remedy the non-compliance.

H.41 COMPLIANCE WITH OTHER MATERIAL CONTRACT PROVISIONS – DAMAGES

If the non-compliance is not corrected by the specified date, the District may assess liquidated damages in the amount of two hundred dollars ($200.00) per working day after the due date until the non-compliance is corrected.

H.42 DEDUCTION OF DAMAGES FROM PAYMENTS

H.42.1 Amounts due the District as liquidated or consequential damages may be deducted by the District from any money payable to the Contractor pursuant to this contract. The Contracting Officer shall notify the Contractor in writing of any claim for liquidated or consequential damages at least thirty (30) days prior to the date the District deducts such sums from money payable to the Contractor. Such amounts as they relate to certification requirements may be deducted during the entire period that MMIS certification is lacking. Should certification subsequently be granted retroactively, the District will reimburse the Contractor for amounts withheld back to the date of certification. The Contractor shall be reimbursed the amount of any recovery from a provider for an overpayment or duplicate payment up to the amount of the consequential damage assessed and collected.

H.42.2 The District may, at its sole discretion, return a portion or all of any liquidated damages collected as an incentive payment to the Contractor for prompt and lasting correction of performance deficiencies.

H.43 GRATUITIES

It is a breach of ethical standards for a payment, gratuity, or offer of employment to be made by or on behalf of a subcontract or order. The District of Columbia may terminate any contract if it is determined that gratuities of any kind were offered/received by any officials, employees or agents of the Contractor. (Chapter 18 of the D.C. Personnel Regulations)

H.44 FINANCIAL REQUIREMENTS

The following subsections address the financial requirements regarding the District of Columbia MMIS.

H.44.1 FINANCIAL ACCOUNTING REQUIREMENTS

H.44.1.1 The Contractor shall maintain accounting records relating directly to performance of this contract. These accounting records shall be maintained in accordance with generally accepted accounting principles. Further, they shall be maintained separate and apart from other corporate accounting records.

H.44.1.2 The Contractor shall maintain, document, and submit operations cost data in accordance with the State Medicaid Manual, Section 11276.10. Documentation shall support and differentiate between contract operations costs for MMIS and non-MMIS services provided by the Contractor that are not reimbursable at the seventy-five percent (75%) matching rate.

H.44.1.3 Authorized representatives or agents of the District and CMS shall have access to the accounting records upon reasonable notice and at reasonable times during the performance and/or retention period of this contract for purposes of review, analysis, inspection, audit, and/or reproduction. Copies of

any accounting records pertaining to the contract shall be made available by the Contractor within ten (10) days of receiving a written request from the District for specified records. If such original documentation is not made available as requested, the Contractor agrees to provide transportation, lodging, and subsistence at no cost, for MAA and other District and/or Federal representatives to carry out their audit function at the principal offices of the Contractor or other locations of such records. MAA and other District and Federal agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm, or corporation insofar as they relate to transactions with any department, board, commission, institution, or other District or Federal agency connected with this contract.

H.44.1.4 Financial records pertaining to this contract will be maintained for three (3) years following the end of the Federal fiscal year during which the contract is terminated or District and Federal audits of the contract have been completed, whichever is later. However, accounting records pertaining to the contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the contract if the litigation has not terminated within the above three-year (3) period. Accounting records and procedures shall be subject to District and Federal approval.

H.44.2 FINANCIAL AUDIT REQUIREMENTS

H.44.2.1 The Contractor shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses of this contract to the extent and in such detail as shall properly reflect all revenues, all net costs, direct and apportioned, and other costs and expenses of whatever nature for which reimbursement is claimed under provisions of the contract.

H.44.2.2 The Contractor shall agree that authorized Federal and District representatives including, but not limited to, MAA personnel, the District Auditor and other District and Federal agencies providing funds, and the Comptroller General of the United States, shall have access to and the right to examine the items listed above during the contract period and during the three-year (3) post-contract period or until final resolution of all pending audit questions and litigation. During the contract period, access to these items will be provided at the Contractor's office in District of Columbia at all reasonable times. During the three-year (3) post-contract period, delivery of and access to the listed items will be at no cost to the District.

H.44.2.3 The provisions of this section shall be incorporated in any subcontract of one hundred thousand dollars ($100,000.00) or more.

H.45 OTHER CONTRACT TERMS AND CONDITIONS

The following subsections address term and conditions not otherwise covered in the preceding subsections of this RFP.

H.45.1 ENVIRONMENTAL PROTECTION

The Contractor shall be in compliance with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 1857(h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR, Part 15) which prohibit the use under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor shall report violations to the applicable grantor Federal agency and the US EPA Assistant Administrator for Enforcement.

H.45.2 PUBLICITY

The Contractor shall at all times obtain the prior written approval from the COTR before it, any of its officers, agents, employees or subcontractors either during or after expiration or termination of the Contract make any statement, or issue any material, for publication through any medium of communication, bearing on the work performed or data collected under this contract.

If the Contractor or any of its subcontractors publishes a work dealing with any aspect of performance under the contract, or of the results and accomplishments attained in such performance, the District shall have a royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use and to authorize others to use the publication.

H.45.3 AWARD OF RELATED CONTRACTS

The District may undertake or award supplemental or successor contracts for work related to this contract or any portion thereof. The Contractor shall be bound to cooperate fully with such other Contractors and the District in all such cases. All subcontractors will be required to abide by this provision as a condition of the contract between the subcontractor and the prime Contractor.

H.45.4 CONFLICT OF INTEREST

No official or employee of MAA and no other public official of the District of Columbia or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this contract shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. (DC Procurement Practices Act of 1985, DC Law 6-85 and Chapter 18 of the DC Personnel Regulations)

The Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the

performance of its services hereunder. The Contractor further covenants that, in the performance of the contract, no person having any such known interests shall be employed.

H.45.5 FINANCIAL RECORDS SUPPLIED TO THE DISTRICT

H.45.5.1 During the entire life of the Contract, the Contractor and all subcontractors shall provide the District with copies of its annual report and all disclosure or reporting statements or forms filed with the District of Columbia and/or the Securities and Exchange Commission (SEC) as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that the Contractor is not required to or does not prepare either an annual report or SEC disclosure or reporting statements or forms by virtue of being a subsidiary of another corporation, it shall fulfill the requirements of this Section with respect to all such documents for any parent corporation which reflect, report or include any of its operations on any basis.

H.45.5.2 Upon the written request of the COTR, the Contractor and all subcontractors shall furnish the District with the most recent unaudited and audited copies of its current balance sheet within fourteen (14) calendar days of its receipt of such request.

H.45.6 TAX EXEMPT STATUS

The Medical Assistance Administration represents that it is exempt from federal excise, District and local taxes, and that sales to it are exempted from District of Columbia sales and use taxes. If in the future the Medical Assistance Administration becomes subject to any such taxes, the Medical Assistance Administration shall reimburse the Contractor for any cost or expense incurred. Any other taxes imposed on the Contractor on account of this Contract shall be borne solely by the Contractor.

H.45.7 TITLES NOT CONTROLLING

Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

H.46 HIPAA Privacy Compliance

H.46.1 Definitions

H.46.1.1 Business Associate. "Business Associate" shall mean Contractor.

H.46.1.2 Covered Entity. "Covered Entity" shall mean District of Columbia, Department of Health, Medical Assistance Administration.

H.46.1.3 Designated Record Set means:

H.46.1.3.1 A group of records maintained by or for Covered Entity that is:

H.46.1.3.1.1 The medical records and billing records about individuals maintained by or for a covered health care provider;

H.46.1.3.1.2 The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

H.46.1.3.1.3 Used, in whole or in part, by or for Covered Entity to make decisions about individuals.

H.46.1.3.2 For purposes of this paragraph, the term *record* means any items, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for Covered Entity.

H.46.1.4 Individual shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

H.46.1.5 Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

H.46.1.6 Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

H.46.1.7 Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

H.46.1.8 Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

H.46.2 Obligations and Activities of Business Associate

H.46.2.1 Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this HIPAA Privacy Compliance Clause (this Clause) or as Required By Law.

H.46.2.2 Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Clause.

H.46.2.3 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Clause.

H.46.2.4 Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Clause of which it becomes aware.

H.46.2.5 Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

H.46.2.6 Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner as provided by the Covered Entity, to Protected Health Information in a Designated Record Set, to the Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.

H.46.2.7 Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual, and in the time and manner specified by the Covered Entity.

H.46.2.8 Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, available to the Covered Entity, or to the Secretary, in a time and manner specified by the Covered Entity or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

H.46.2.9 Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

H.46.2.10 Business Associate agrees to provide to Covered Entity or an Individual, in time and manner specified by the Covered Entity, information collected in accordance with Section (i) above, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

H.46.3 Permitted Uses and Disclosures by Business Associate

H.46.3.1 Refer to underlying services agreement:

H.46.3.1.1 Except as otherwise limited in this Clause, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services

for, or on behalf of, Covered Entity as specified in the Contract provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

H.46.3.1.2 Except as otherwise limited in this Clause, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

H.46.3.1.3 Except as otherwise limited in this Clause, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

H.46.3.1.4 Except as otherwise limited in this Clause, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

H.46.3.1.5 Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

H.46.4 Obligations of Covered Entity

H.46.4.1 Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

H.46.4.2 Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

H.46.4.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that

such restriction may affect Business Associate's use or disclosure of Protected Health Information.

H.46.5 Permissible Requests by Covered Entity

H.46.5.1 Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

H.46.6 Term and Termination

H.46.6.1 Term. The requirements of this HIPAA Privacy Compliance Clause shall be effective as of the date of contract award, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

H.46.6.2 Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Clause by Business Associate, Covered Entity shall either:

H.46.6.2.1 Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

H.46.6.2.2 Immediately terminate the contract if Business Associate has breached a material term of this HIPAA Privacy Compliance Clause and cure is not possible; or

H.46.6.2.3 If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

H.46.6.3 Effect of Termination.

H.46.6.3.1 Except as provided in paragraph (2) of this section, upon termination of the contract, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

H.46.6.3.2 In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon determination by the Contracting Officer that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

H.46.7 Miscellaneous

H.46.7.1 Regulatory References. A reference in this Clause to a section in the Privacy Rule means the section as in effect or as amended.

H.46.7.2 Amendment. The Parties agree to take such action as is necessary to amend this Clause from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191.

H.46.7.3 Survival. The respective rights and obligations of Business Associate under Section (6) of this Clause and Sections 9 and 20 of the Standard Contract Provisions for use with District of Columbia Government Supply and Services Contracts, effective April 2003, shall survive termination of the contract.

H.46.7.4 Interpretation. Any ambiguity in this Clause shall be resolved to permit Covered Entity to comply with the Privacy Rule.

H.47 System Audit Standard 70 (SAS 70) – Audit of MMIS Scope of work

H.47.1 The Contractor shall hire an independent consultant as described in Section C.3.1 (5), with the approval of the District that will perform a Type II audit in accordance with Generally Accepted Auditing Standards (GAAS) for the purpose of expressing an opinion on the design of the policies and procedures placed in operation, as well as the operating effectiveness of such policies and procedures by:

1. Examination of the District's Contractor and its operations of the Medicaid Management Information Services (MMIS) and the procedures for documenting program changes, file protection and security of user records.

2. Examination of program documentation.

3. Examination of controls related to the input, processing and output phases of the applications.

4. Tests of processing under normal operating conditions.

5. Tests of output and results of compliance with the system design.

6. Express an opinion on the service organization's description of controls and whether the controls were operating with sufficient effectiveness to provide reasonable assurance that the control objectives were achieved during the district's fiscal year.

7. Accomplish audit work in accordance with the following schedule:

   a) Complete all examination and testing by November 15 each year.
   b) Issue Type II Service Auditor's Report by November 30 each year.

   c) The Contractor will not be held to the time frames if in the event of the DC MMIS system failure or other extraordinary circumstances such as an act of terrorism.

   d) To provide the District the maximum flexibility in managing this contract and dictating priorities, it may waive periodically the above-mentioned time frames; however, over the course of the contract the time frames shall be met except for permanent changes approved by the Issuing Office in writing.

8. Assure orderly transfer of responsibility should the need arise to transition from one Contractor to another.

9. The Contractor shall describe in detail their technical approach for examination and testing. The technical proposal shall outline the proposed procedures for performing the SAS 70 audit.

10. Maintain and organize working papers in a manner agreeable to both the Issuing Office and the Contractor.

H.47.2 General Format for SAS Report

H.47.2.1 The Contractor should require the Two Part Submission that need to be reviewed by MAA

H.47.2.1.1 Contractors shall submit in separate sealed envelopes technical and financial proposals in the following manner:

H.47.2.1.1.1 Two originals (to be so labeled) and five copies of the technical proposal in a sealed envelope clearly labeled "Technical Proposal"; and,

H.47.2.1.1.2 Two originals (to be so labeled) and five copies of the financial proposal in a sealed envelope clearly labeled "Financial Proposal".

H.47.2.2 Transmittal Letter

H.47.2.2.1 Proposals are to be accompanied by a brief transmittal letter prepared on the Contractor' s letterhead, and signed by an individual who is authorized to commit the Contractor to the service and requirements as stated in the SOW. This letter will state:

H.47.2.2.1.1 The name, title, address, and telephone number of the person authorized to bind the Contractor to the contract, and who will receive all official notices concerning this SOW; and

H.47.2.2.1.2 The Contractor' s Federal Tax Identification Number or Social Security Number.

H.47.3 Technical Proposal

H.47.3.1 Format

H.47.3.1.1 The District will require Proposals that shall be clear and precise, and shall affirmatively address all points as outlined in Part I. All Contractors shall present their technical proposal in the following manner:

H.47.3.1.2 The volume must contain sufficient information to enable the evaluators to assess the proposal in accordance with the mandatory requirements listed below. It should be prepared in a clear and precise manner and should address all appropriate aspects of this SOW except pricing proposal.

H.47.3.2 Mandatory Requirements

H.47.3.2.1 All proposals must include the following mandatory items:

H.47.3.2.1.1 Location of the local office or the establishment of a local office.

H.47.3.2.1.2 Assurance that the Contractor will be available beyond the termination of this contract for the defense of any auditing and related accounting services including, but not limited to, providing documents and witnesses.

H.47.3.3 Other Technical Proposal Requirements

H.47.3.3.1 The Contractor cannot, during the term of this contract, have any conflict of interest. Contract must notify the Issuing Office of any potential conflict of interest and a description given of the circumstance of the potential conflict of interest. In addition, the Contractor must present to the Issuing Office the steps they will take to eliminate the conflict. The Contractor will also inform the Issuing Office of any audit staff who seeks employment with the Contractor while an audit is in progress. The prospective Contractor shall refer to the AICPA professional code of ethics whenever a conflict arises during the duration of the contract. The District reserves the right to approve the Contractor's conflict elimination plan.

H.47.3.3.2 Experience of Contractor & Qualifications of Personnel

1) Present sufficient material to demonstrate the firm's prior work experience with Medicaid cost report auditing, rebasing techniques, and forecasting Medicaid accruals. Also, Contractors shall demonstrate a prior experience in performing similar services for the District of Columbia's Medical Assistance Administration and any other relevant experience relating to the District Government's financial operations. The aforementioned will be used to support the Contractor's qualifications to successfully complete this project.

2) Present references that include name of firm, point of contact including telephone number, and a brief description of work performed.

3) Demonstrate the mix of experienced personnel who will work on this contract.

4) Furnish resumes that include work history and the educational background of the Partner, Principal or Corporate Official for this contract and the Supervising Auditors that will be assigned to this contract. During the term of the contract, if there is any change to principal or partner, the Contractor shall notify the Issuing Office of such change.

5) It is essential that the firm assign sufficient qualified staff that has experience in the health care industry. The Contractor will be held to this distribution of effort for the entire term of this contract.

H.47.4 Staff Requirements

H.47.4.1 The MMIS Contractor will request of the consultant that the majority of the employees assigned to this contract be employed on a full-time basis.

H.47.4.2 The prospective Contractor's audit staff shall comply with, at a minimum, the following qualifications and anticipated responsibilities:

H.47.4.2.1 Partner

H.47.4.2.1.1 A partner of the firm who is a licensed certified public accountant (CPA), and who possesses substantial experience in auditing Medicaid rules and regulations, the partner who bears the ultimate responsibility for the engagement shall also have demonstrated knowledge of the health care industry.

H.47.4.2.2 Supervisory Auditors

H.47.4.2.2.1 Upper-level accounting and auditing personnel who are CPAs and who must be either a partner, or a manager, or a supervisor with more than five years experience in auditing Medicaid cost reports. The responsibilities include overall planning, organization, scheduling, supervision, problem solving, position paper preparation, technical consulting and completion of several simultaneous engagements.

H.47.4.2.3 Senior Auditors

H.47.4.2.3.1 Mid-level accounting and auditing personnel who must have one to three

years experience in auditing in the health care industry. They will be directly responsible for the field work and for the supervision of entry-level auditors. Each senior auditor shall have a degree and will typically spend 75% or more of their time working in the field of health care industry.

H.47.3 The Issuing Office must approve any changes to the aforementioned levels of audit personnel and the related minimum qualifications and/or anticipated responsibilities in writing. Resumes of the proposed staff must satisfy the requirements outlined above. The Management staff is expected to be employed in the local office of the proposing firm.

H.47.4 Deliverables

H.47.4.1 The Contractor shall deliver seven (7) copies of the audit report no later than December 31 each year. The report shall attest to whether the control policies and procedures were suitably designed to achieve the control objectives specified by management of the Contractor; if those policies and procedures satisfactorily complied with the control objectives; and that such policies and procedures were in operation as of September 30 each year.

H.48 – HIPAA Security ongoing yearly assessment and penetration test

The Contractor shall hire an independent consultant with the approval of the District that will perform independent on going yearly assessment and penetration test or when major changes applied to the MMIS processing to conform with the Health Insurance Portability and Accountability Act (HIPAA), better know as the Kennedy-Kassebaum Bill, was signed into law on August 21, 1996. On February 13, 2003, the United States Department of Health and Human Services' (HHS) Secretary Tommy Thompson announced the adoption of the HIPAA Security Final Rule [45 CFR §160, 162 and 164]. The final standards were published in the February 20, 2003, Federal Register with an effective date of April 21, 2003.

H.48.1 To ensure that all electronic protected health information that MAA-MMIS creates, receives, maintains and/or transmits remains confidential and is not compromised;

H.48.2 To protect against any reasonably anticipated threats or hazards to the security or integrity of protected health information;

H.48.3 To protect against any reasonably anticipated uses or disclosures of protected health information that are required by the HIPAA Privacy Rule;

H.48.4 Security Rule Gap Analysis –

This ongoing analysis shall evaluate the extent of existing HIPAA Security Rule compliance of the MMIS operating environment within the Contractor, at the data centers and the Fiscal Agency office in Washington DC.

H.48.4.1 The Security Rule Gap Analysis shall:

H.48.4.1.1 Provide a guide for internal verification of MMIS HIPAA security compliance and or the remediation of any deficiencies during the security implementation phase of the compliance project;

H.48.4.1.2 Provide documented evidence of due diligence;

H.48.4.1.3 Document the degree of Security Rule compliance of the MAA MMIS operating environment;

H.48.4.1.4 Facilitate the collaboration of MAA with CMS and with all its business partners in the compilation of best of breed, HIPAA compliant security practices to address threats and vulnerabilities and to implement advanced security practices within the MAA-MMIS processing environment;

H.48.4.1.5 Serve as initial foundation for eventual Implementation of final documentation of Security Rule compliance for purposes of verification and assessment by outside reviewers and auditors;

H.48.4.1.6 Assure MAA management, customers, CMS and the DC Secretary of Health and Human Resources that appropriate steps are being taken to protect health information;

H.48.4.1.7 Train MAA to demonstrate to regulators and other stakeholders that the organization has taken reasonable steps to achieve compliance with the HIPAA Security Rule.

H.48.5 Penetration Testing: The objectives of the planned ongoing penetration testing shall include:

H.48.5.1 Complete evaluation of the ability of the MMIS intrusion detection system to detect an attack;

H.48.5.2 Complete evaluation of the appropriateness of the MMIS incident response procedures;

H.48.5.3 Complete evaluation of the amount of information a hacker or other intruder can learn about Contractor network through breeching MMIS network access controls;

H.48.5.4 Complete assessment of the strength of MMIS existing physical security;

H.48.5.5 Complete evaluation of the adequacy of the information provided to MAA employees and Contractor through the HIPAA security awareness program (i.e., are employees using strong passwords, do they turn off terminals when the terminals are not in use).

H.48.6 Intrusion Detection Systems (IDS)

The Contractor shall install, configure and maintain the Network Intrusion Detection and Host based Intrusion detection systems safeguarding the ePHI data. The Contractor shall

H.48.6.1 Install the NIDS/HIDS software.

H.48.6.2 Test the NIDS/HIDS software.

H.48.6.3 Involve network team(s) to ensure full visibility to traffic on the segment located at the DC MMIS Contractor Services locations

H.48.6.4 Involve network team(s) to ensure adequate bandwidth and routing back to the Security Operations Center

H.48.6.5 Develop and establish notification and escalation procedures.

H.48.6.7 Conduct on-going monitoring (24X7X365)

SECTION I: CONTRACT CLAUSES

I.1 APPLICABILITY OF STANDARD CONTRACT PROVISIONS

The Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts dated November 2004 ("SCP"), are incorporated as part of the contract resulting from this solicitation. To obtain a copy of the SCP go to www.ocp.dc.gov, click on OCP Policies under the heading "Information", then click on "Standard Contract Provisions – Supplies and Services Contracts".

I.2 CONTRACTS THAT CROSS FISCAL YEARS

Continuation of this contract beyond the current fiscal year is contingent upon future fiscal appropriations.

I.3 CONFIDENTIALITY OF INFORMATION

All information, and, in particular, information relating to recipients and providers, obtained by the Contractor through performance of its duties under this contract, shall be treated as confidential information to the extent required by the laws of the District of Columbia and the United States. Individual identifiable information shall not be disclosed without prior written approval of the COTR.

All Contractor employees shall be instructed, in writing, of this requirement and shall be required to sign a document to this effect upon employment and annually thereafter.

Disclosure of information in summary, statistical, or other form which does not identify particular individuals will be approved by the District. Use of all such information shall be limited to purposes directly related to the administration of the Medicaid program in District of Columbia.

I.4 TIME

Time, if stated in a number of days, will include Saturdays, Sundays, and holidays, unless otherwise stated herein.

I.5 RIGHTS IN DATA

I.5.1 "Data," as used herein, means recorded information, regardless of form or the media on which it may be recorded. The term includes technical data and computer software. The

term does not include information incidental to contract administration, such as financial, administrative, cost or pricing, or management information.

I.5.2 The term "Technical Data", as used herein, means recorded information, regardless of form or characteristic, of a scientific or technical nature. It may, for example, document research, experimental, developmental or engineering work, or be usable or used to define a design or process or to procure, produce, support, maintain, or operate material. The data may be graphic or pictorial delineations in media such as drawings or photographs, text in specifications or related performance or design type documents or computer printouts. Examples of technical data include research and engineering data, engineering drawings and associated lists, specifications, standards, process sheets, manuals, technical reports, catalog item identifications, and related information, and computer software documentation. Technical data does not include computer software or financial, administrative, cost and pricing, and management data or other information incidental to contract administration.

I.5.3 The term "Computer Software", as used herein means computer programs and computer databases. "Computer Programs", as used herein means a series of instructions or statements in a form acceptable to a computer, designed to cause the computer to execute an operation or operations. "Computer Programs" include operating systems, assemblers, compilers, interpreters, data management systems, utility programs, sort merge programs, and automated data processing equipment maintenance diagnostic programs, as well as applications programs such as payroll, inventory control and engineering analysis programs. Computer programs may be either machine-dependent or machine-independent, and may be general purpose in nature or designed to satisfy the requirements of a particular user.

I.5.4 The term "computer databases", as used herein, means a collection of data in a form capable of being processed and operated on by a computer.

I.5.5 All data first produced in the performance of this contract shall be the sole property of the District. Contractor hereby acknowledges that all data including, without limitation, computer program codes produced by Contractor for the District under this Contract are works made for hire and are the sole property of the District; but, to the extent any such data may not, by operation of law, be works made for hire, Contractor hereby transfers and assigns to the District the ownership of copyright in such works, whether published or unpublished. The Contractor agrees to give the District all assistance reasonably necessary to perfect such rights including, but not limited to, the works and supporting documentation and the execution of any instrument required to register copyrights. The Contractor agrees not to assert any rights at common law or in equity in such data. The Contractor shall not publish or reproduce such data in whole or in part or in any manner or form, or authorize others to do so, without written consent of the District until such time as the District may have released such data to the public.

I.5.6 OWNERSHIP OF THE SYSTEM

I.5.6.1 The District of Columbia and CMS own any software designed, developed, installed or enhanced under the terms of the contract resulting from this solicitation pursuant to 42 CFR, Subpart C and Part 11 of the State Medicaid Manual. The Contractor agrees

that the District of Columbia and the United States Department of Health and Human Services (USDHHS) shall have a non-exclusive, royalty-free, and irrevocable license to reproduce or otherwise use and authorize others to use, for Federal Government purposes**,** the software, procedures, files, and other documentation constituting the District of Columbia MMIS at any time during the period of the contract and thereafter.

I.5.6.2 The Contractor agrees to provide to the District in escrow, with a third party agreed to by the District, all MMIS programs, including source code, scripts, JCL, and other such items and materials that the District may from time to time identify. The items in escrow must be not older than 30 days. The escrow agent will Turnover to the District what is so stored in case the Contractor no longer exists, goes into bankruptcy, or is placed in receivership. The Contractor agrees to deliver such material to the District within thirty (30) days from receipt of the request by MAA. Such requests may be made by MAA at any time prior to the expiration of the contract.

I.5.6.3 The license shall include, but is not limited to:

a) All District of Columbia MMIS and supporting programs in their most current version;

b) All job control language (JCL) or other system instructions for operating the District of Columbia MMIS, in their most current version;

c) All data files in their most current version;

d) User and operational manuals and other documentation;

e) System and program documentation describing the most current version of the District of Columbia MMIS, including the most current versions of source and object code;

f) Training programs for MAA staff and other designated District employees for the operation and use of the system;

g) Any and all performance-enhancing operational plans and products;

h) Training programs for providers and other billing agents for claims submission (both paper and EMC) and use of then recipient Eligibility Verification System; and

i) All specialized or specially modified operating system software and specially developed programs, including utilities, software, electronic claims submission packages, and documentation, which are required for, or used in the operation of, the District of Columbia MMIS but which may not be considered as being developed or modified under this contract.

I.5.6.4 Proprietary software proposed for use within a functional area of the planned District of Columbia MMIS may be exempt from this ownership clause. Exemptions would be granted if the proprietary product is defined as such and with sufficient specificity in the offeror's proposal that the District can determine whether to fully accept it as the desired solution during proposal evaluation. The Contractor shall be required to provide sufficient information regarding the objectives and specifications of any proprietary software to allow its functions to be duplicated by other commercial or public domain products.

I.5.6.5 Any other specialized software that is not covered under a public domain license that will be integrated into the District of Columbia MMIS shall be identified as to its commercial source.

I.5.6.6 Proprietary software solutions will not be allowed as part of the ongoing development of MMIS features, and all system modifications made after start of operations will be funded jointly by District and Federal financial participation.

I.5.6.7 A fundamental obligation imposed on the Contractor is for the transfer by the Contractor to the District of ownership rights in the District of Columbia MMIS, whether developed or obtained by the Contractor in the course of performance under the contract or before it. This obligation to transfer ownership rights on the part of the Contractor is subject to the limitations described above.

I.5.6.8 The exception to this requirement on ownership rights is for the use of commercial software which requires that such software be available to the District on the open market and not has been modified in any manner. It is the responsibility of the Contractor to demonstrate that the software is available through other sources.

I.5.6.9 License Title to the system shall be transferred to the District, including portions (for example, documentation) as they are created during the Enhancement and Implementation Task and subsequently as modifications for future changes to the MMIS are approved and installed.

I.5.6.10 The Contractor shall convey, upon request and without limitation, copies of all system documentation, operating instructions, and procedures and all data processing programs, or portions thereof, which are part of the planned District of Columbia MMIS, whether they are developed by the employees of the Contractor or any subcontractor as part of this contract or transferred from another MMIS or contract.

I.5.7 The restricted rights set forth in paragraph I.5.6 are of no effect unless (i) the computer software is marked by the Contractor with the following legend:

RESTRICTED RIGHTS LEGEND

Use, duplication, or disclosure is subject to restrictions stated in
Contract No. _____

With _____ (Contractor's Name)

and (ii) The related computer software documentation includes a prominent statement of the restrictions applicable to the computer software. The Contractor shall not place any legend on computer software indicating restrictions on the District's rights in such software unless the restrictions are set forth in a license or Contract made a part of the contract prior to the delivery date of the software. Failure of the Contractor to apply a restricted rights legend to such computer software shall relieve the District of liability with respect to such unmarked software.

I.5.8 In addition to the rights granted in paragraph I.5.6 above, the Contractor hereby grants to the District a nonexclusive, paid-up license throughout the world, of the same scope as restricted rights set forth in paragraph I.5.6 above, under any copyright owned by the Contractor, in any work of authorship prepared for or acquired by the District under the contract. Unless written approval of the Contracting Officer is obtained, the Contractor shall not include in technical data or computer software prepared for or acquired by the District under the contract any works of authorship in which copyright is not owned by the Contractor without acquiring for the District any rights necessary to perfect a copyright license of the scope specified in the first sentence of this paragraph.

I.5.9 Whenever any data, including computer software, are to be obtained from a subcontractor under this contract, the Contractor shall use this same clause in the subcontract, without alteration, and no other clause shall be used to enlarge or diminish the District's or the Contractor's rights in that subcontractor data or computer software which is required for the District.

I.5.10 For all computer software furnished to the District with the rights specified in paragraph I.5.6, the Contractor shall furnish to the District a copy of the source code with such rights of the scope specified in paragraph I.5.5. For all computer software furnished to the District with the restricted rights specified in paragraph I.5.6, the District, if the Contractor, either directly or through a successor or affiliate shall cease to provide the maintenance or warranty services provided the District under this contract or any paid-up maintenance contract, or if Contractor should be declared bankrupt or insolvent by a court of competent jurisdiction, shall have the right to obtain, for its own and sole use only, a single copy of the then current version of the source code supplied under this contract, and a single copy of the documentation associated therewith, upon payment to the person in control of the source code the reasonable cost of making each copy.

I.5.11 The Contractor shall indemnify and save and hold harmless the District, its officers, agents and employees acting within the scope of their official duties against any liability, including costs and expenses, (i) for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract, or (ii) based upon any data furnished under this contract, or based upon libelous or other unlawful matter contained in such data.

I.5.12 Nothing contained in this clause shall imply a license to the District under any patent, or be construed as affecting the scope of any license or other right otherwise granted to the District under any patent.

I.5.13 Paragraphs I.5.6, I.5.7, I.5.8, I.5.11, and I.5.12 above are not applicable to material furnished to the Contractor by the District and incorporated in the work furnished under contract, provided that such incorporated material is identified by the Contractor at the time of delivery of such work.

I.5.14 All software and related documentation prepared or acquired by the Contractor for the District under this contract shall carry the following standard heading on the front cover, title page or, in the case of programs, in the title block:

DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

I.5.14.1 The Contractor shall use Medical Assistance Administration-owned data, software and related documentation, before and after the expiration or termination of this contract, only as required for the performance of this Contract (see also Subsection I.9.12, "CONFIDENTIALITY"). It will not otherwise use, copy or reproduce the same in any form, except pursuant to the express written instructions of the Medical Assistance Administration or the CMS.

I.5.14.2 The Contractor further agrees to deliver the same to the Medical Assistance Administration promptly upon request, or upon expiration or termination of this Contract, in whatever form it is maintained by the Contractor, and to destroy all copies remaining in its possession, including machine-readable copies. The Contractor will take all reasonable steps during the MMIS Enhancement and Implementation and Operations Tasks to assure the physical security of Medical Assistance Administration-owned data, software and related documentation in its possession including, but not limited to, protection against damage from fire, smoke and water, and security measures enumerated in Subsection I.3, "CONFIDENTIALITY."

I.5.15 INSPECTION OF WORK PERFORMED

The Medical Assistance Administration or any authorized representative of the District of Columbia, the US Department of Health and Human Services, the US Comptroller General, the US General Accounting Office, or their authorized representatives shall, at all reasonable times, have the right to enter the Contractor's premises or such other places where duties under this contract are being performed to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The Contractor and all subcontractors must provide reasonable access to all facilities and assistance to the District and Federal representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work.

I.5.16 RECORDS RETENTION REQUIREMENTS

The Contractor shall maintain records of all claims received, transactions processed, and adjudication decisions made by the system. These records must include all financial and programmatic records, supporting documents, statistics, and other records of recipients for a period of three (3) years from the last date of decision, in accordance with 45 CFR 74.164. Microform copies of such records that meet the standards in 42 CFR 431.17 may be substituted for original records.

I.5.17 USE AND DELIVERY OF FILES

Upon the written request of the COTR during the MMIS Enhancement and Implementation or Operation Tasks, the Contractor shall deliver to the Medical Assistance Administration copies of any data or program file(s) in the MMIS. Each request shall identify the files and the version, sequence, media and number of copies desired. The Contractor shall fulfill each request within three (3) business days of its receipt. The Contractor shall receive no additional compensation for production and delivery of such files.

I.5.18 BACKUP PROCEDURES

The Contractor shall keep in a separate and safe place additional copies of all MMIS records and Medical Assistance Administration data required to be maintained or additional programs, documentations, source code, manuals and data tapes or disks necessary to reproduce all such records and Medical Assistance Administration data. The Contractor shall use reasonable care (minimally meeting applicable IRS standards) to minimize the likelihood of all damage, loss of data, delays, and errors resulting from an uncontrollable event, and should such damage, loss of data, delays, and errors occur the Contractor shall use its best efforts to mitigate the effects of such occurrence. At the COTR's request, the Contractor shall deliver to the Medical Assistance Administration a monthly backup tape of all the Medical Assistance Administration's data at the Contractor's expense. In the event of loss of data by the Contractor, the Contractor shall regenerate the lost data at the Contractor's expense.

I.5.19 DELIVERY OF SYSTEM DOCUMENTATION

Within thirty (30) days following the District acceptance of the MMIS, approximately two (2) months prior to the scheduled on-site CMS review to determine MMIS system eligibility for enhanced FFP and upon written request from the COTR, the Contractor will deliver to the District, three (3) print copies of all systems, programming and operations documentation and User and Procedure Manuals. The documentation must be current as of the date requested, on Medical Assistance Administration-approved forms and must not reference the Contractor.

As modifications and additions are thereafter made to the system, three (3) print copies of the updated documentation shall be forwarded to the Medical Assistance Administration within one (1) week of the Contractor's receipt of the Technical Sign-off. At the Medical

Assistance Administration's option, one (1) IBM PC compatible 3 ½ inch floppy disk copy or one (1) data CD-R containing the above documentation may be substituted for one (1) of the printed copies.

I.6 OTHER CONTRACTORS

The Contractor shall not commit or permit any act, which will interfere with the performance of work by another District Contractor or by any District employees. If another Contractor is awarded a future contract for performance of the required services, the Contractor shall cooperate fully with the District and the new Contractor in any transition activities, which the Contracting Officer deems necessary during the term of the contract.

I.7 SUBCONTRACTS

The Contractor hereunder shall not subcontract any of the Contractor's work or services to any subcontractor without the prior written consent of the Contracting Officer. Any work or service so subcontracted shall be performed pursuant to a subcontract agreement, which the District will have the right to review and approve prior to its execution by the Contractor. Any such subcontract shall specify that the Contractor and the subcontractor shall be subject to every provision of this contract. Notwithstanding any such subcontract approved by the District, the Contractor shall remain liable to the District for all Contractor's work and services required hereunder.

I.8 INSURANCE

I.8.1 Contractor shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall submit a certificate of insurance giving evidence of the required coverages prior to commencing work. All insurance shall be written with responsible companies licensed by the District of Columbia's Department of Insurance, Securities and Banking. The Contractor shall require all subcontractors to carry the insurance required herein, or Contractor may, at its option, provide the coverage for any or all subcontractors, and if so, the evidence of insurance submitted shall so stipulate. All insurance provided by the Contractor as required by this section, except comprehensive automobile liability insurance, shall set forth the District as an additional named insured. In no event shall work be performed until the required certificates of insurance have been furnished. The insurance shall provide for 30 days' prior written notice to be given to the District in the event coverage is substantially changed, canceled or non-renewed. If the insurance provided is not in compliance with all the requirements herein, the District maintains the right to stop work until proper evidence is provided.

I.8.1.1 Commercial General Liability Insurance, $2,000,000 limits per occurrence, District added as an additional insured.

I.8.1.2 Automobile Liability Insurance, $1,000,000 per occurrence combined single limit.

I.8.1.3 Worker's Compensation Insurance according to the statutes of the District of Columbia, including Employer's Liability, $100,000 per accident for injury, $100,000 per employee for disease, $500,000 policy limit disease.

I**.8.1.4 Errors and Omissions Liability Insurance**, $1,000,000 limits per claim

I.8.2 All insurance provided by the Contractor as required by this section, except comprehensive automobile liability insurance, shall set forth the District as an additional insured. All insurance shall be written with responsible companies licensed by the District with duplicate copies to be delivered to the District's Contracting Officer within fourteen (14) days of contract award. The policies of insurance shall provide for at least thirty (30) days written notice to the District prior to their termination or material alteration.

I.9 EQUAL EMPLOYMENT OPPORTUNITY

In accordance with the District of Columbia Administrative Issuance System, Mayor's Order 85-85 dated June 10, 1985, the forms for completion of the Equal Employment Opportunity Information Report are incorporated herein as Section J.2.2. An award cannot be made to any offeror who has not satisfied the equal employment requirements.

I.10 ORDER OF PRECEDENCE

Any inconsistency in this solicitation shall be resolved by giving precedence in the following order: the Supplies or Services and Price/Cost Section (Section B), Specifications/Work Statement (Section C), the Special Contract Requirements (Section H), the Contract Clauses (Section I), and the SCP.

I.11 CONTRACTS IN EXCESS OF $1 MILLION DOLLARS

Any contract in excess of $l,000,000 shall not be binding or give rise to any claim or demand against the District until approved by the Council of the District of Columbia and signed by the Contracting Officer.

I.12 CONTINUITY OF SERVICES

I.12.1 The Contractor recognizes that the services provided under this contract are vital to the District of Columbia and must be continued without interruption and that, upon contract expiration or termination, a successor, either the District or another Contractor, at the District's option, may continue to provide these services. To that end, the Contractor agrees to:

I.12.1.1 Furnish phase-out, phase-in (transition) training; and

I.12.1.2 Exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.

I.12.2 The Contractor shall, upon the Contracting Officer's written notice:

I.12.2.1 Furnish phase-in, phase-out services for up to 90 days after this contract expires and

I.12.2.2 Negotiate in good faith a plan with a successor to determine the nature and extent of phase-in, phase-out services required. The plan shall specify a training program and a date for transferring responsibilities for each division of work described in the plan, and shall be subject to the Contracting Officer's approval.

I.12.3 The Contractor shall provide sufficient experienced personnel during the phase-in, phase-out period to ensure that the services called for by this contract are maintained at the required level of proficiency.

I.12.4 The Contractor shall allow as many personnel as practicable to remain on the job to help the successor maintain the continuity and consistency of the services required by this contract. The Contractor also shall disclose necessary personnel records and allow the successor to conduct on-site interviews with these employees. If selected employees are agreeable to the change, the Contractor shall release them at a mutually agreeable date and negotiate transfer of their earned fringe benefits to the successor [consent of employees?].

I.12.5 Only in accordance with a modification issued by the Contracting Officer, the Contractor shall be reimbursed for all reasonable phase-in, phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract.

I.13 COST-REIMBURSEMENT COMPONENT

This contract includes a cost-reimbursement component as set forth in Section B.2 (3), only costs determined in writing to be reimbursable by the Contracting Officer, in accordance with the cost principles set forth in rules issued pursuant to Title VI of the Procurement Practices Act of 1985 shall be reimbursable.

SECTION J: LIST OF ATTACHMENTS

J.1 ATTACHMENT

J.1.1 Wage Determination No. 1994-2103, Revision No. 35, dated 5/23/2006

J.2 INCORPORATED ATTACHMENTS *(The following forms, located at www.ocp.dc.gov shall be completed and incorporated with the offer.)*

J.2.1 LSDBE Certification Package

J.2.2 E.E.O. Information and Mayor' s Order 85-85

J.2.3 Tax Certification Affidavit

J.2.4 First Source Employment Agreement

J.2.5 Cost/Price Data Package

SECTION K: REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS

K.1 CERTIFICATION REGARDING A DRUG-FREE WORKPLACE (JULY 1990)

K.1.1 Definitions. As used in this provision:

K.1.1.1 Controlled substance: means a controlled substance in schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. § 812) and as further defined in regulation at 21 CFR 1308.11 - 1308.15.

K.1.1.2 Conviction: means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

K.1.1.3 Criminal drug statute: means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

K.1.1.4 Drug-free workplace: means the site(s) for the performance of work done by the Contractor in connection with a specific contract at which employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

K.1.1.5 Employee: means an employee of a contractor directly engaged in the performance of work under a District contract. "Directly engaged" is defined to include all direct cost employees and any other contractor employee who has other than a minimal impact or involvement in contract performance.

K.1.1.6 Individual: means an offeror/contractor that has no more than one employee including the offeror/contractor.

K.1.2 The Contractor, if other than an individual, shall within 30 days after award (unless a longer period is agreed to in writing for contracts of 30 days or more performance duration), or as soon as possible for contracts of less than 30 days performance duration:

(1) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor's

workplace and specifying the actions that will be taken against employees for violations of such prohibition;

(2) Establish an ongoing drug-free awareness program to inform such employees about:

a. The dangers of drug abuse in the workplace;
b. The Contractor's policy of maintaining a drug-free workplace;
c. Any available drug counseling, rehabilitation, and employee assistance programs; and
d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by section K.x.2(1) of this clause;

(4) Notify such employees in writing in the statement required by section K.x.2(1) of this clause that, as a condition of continued employment on this contract, the employee will:

a. Abide by the terms of the statement; and
b. Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction.

(5) Notify the Contracting Officer in writing within 10 days after receiving notice under section K.x.2(4)(b) of this clause, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;

(6) Within 30 days after receiving notice under section K.x.2(4)(b) of this clause of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

a. Take appropriate personnel action against such employee, up to and including termination; or
b. Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(7) Make a good faith effort to maintain a drug-free workplace through implementation of section K.x.2(1) through K.x.2(6) of this clause.

K.1.3 The Contractor, if an individual, agrees by award of the contract or acceptance of a purchase order, not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

K.1.4 In addition to other remedies available to the District, the Contractor's failure to comply with the requirements of sections K.x.2 or K.x.3 of this clause may render the Contractor subject to suspension of contract payments, termination of the contract for default, and suspension or debarment.

K.2 TYPE OF BUSINESS ORGANIZATION

K.2.1 The offeror, by checking the applicable box, represents that

(a) It operates as:

__ a corporation incorporated under the laws of the State of: _____
__ an individual,
__ a partnership,
__ a nonprofit organization, or
__ a joint venture.

(b) If the offeror is a foreign entity, it operates as:

__ an individual,
__ a joint venture, or
__ a corporation registered for business in _____
(Country)

K.3 AUTHORIZED NEGOTIATORS

K.3.1

The offeror represents that the following persons are authorized to negotiate on its behalf with the District in connection with this request for proposals: (list names, titles, and telephone numbers of the authorized negotiators).

.....

.....

.....

K.4 CERTIFICATION AS TO COMPLIANCE WITH EQUAL OPPORTUNITY OBLIGATIONS

Mayor's Order 85-85, "Compliance with Equal Opportunity Obligations in Contracts", dated June 10, 1985 and the Office of Human Rights' regulations, Chapter 11, "Equal Employment Opportunity Requirements in Contracts", promulgated August 15, 1986 (4 DCMR Chapter 11, 33 DCR 4982) are included as a part of this solicitation and require the following certification for contracts subject to the order. Failure to complete the certification may result in rejection of the offeror for a contract subject to the order. I hereby certify that I am fully aware of the content of the Mayor's Order 85-85 and the Office of Human Rights' regulations, Chapter 11, and agree to comply with them in performance of this contract.

Offeror_____Date_____

Name_____Title_____

Signature_____

Offeror ____has ____has not participated in a previous contract or subcontract subject to the Mayor's Order 85-85. Offeror____has ____has not filed all required compliance reports, and representations indicating submission of required reports signed by proposed subofferors. (The above representations need not be submitted in connection with contracts or subcontracts which are exempt from the Mayor's Order.)

K.5 BUY AMERICAN CERTIFICATION

The offeror hereby certifies that each end product, except the end products listed below, is a domestic end product (See Clause 23 of the SCP, "Buy American Act"), and that components of unknown origin are considered to have been mined, produced, or manufactured outside the United States.

_____EXCLUDED END PRODUCTS
_____COUNTRY OF ORIGIN

K.6 DISTRICT EMPLOYEES NOT TO BENEFIT CERTIFICATION

Each offeror shall check one of the following:

_____ No person listed in Clause 13 of the SCP, "District Employees Not To Benefit" will benefit from this contract.

_____ The following person(s) listed in Clause 13 may benefit from this contract. For each person listed, attach the affidavit required by Clause13 of the SCP.

_____

_____

K.7 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

(a) Each signature of the offeror is considered to be a certification by the signatory that:

1) The prices in this contract have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any offeror or competitor relating to:

(i) those prices
(ii) the intention to submit a contract, or
(iii) the methods or factors used to calculate the prices in the contract.

2) The prices in this contract have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before contract opening unless otherwise required by law; and

3) No attempt has been made or will be made by the offeror to induce any other concern to submit or not to submit a contract for the purpose of restricting competition.

(b) Each signature on the offer is considered to be a certification by the signatory that the signatory;

1) Is the person in the offeror' s organization responsible for determining the prices being offered in this contract, and that the signatory has not participated and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above; or

2) Has been authorized, in writing, to act as agent for the following principals in certifying that those principals have not participated, and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above:

_____

(*insert full name of person(s) in the organization responsible for determining the prices offered in this Contract and the title of his or her position in the offeror' s organization);*

(i) As an authorized agent, does certify that the principals named in subdivision (b)(2) have not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above; and

(ii) As an agent, has not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above.

(c) If the offeror deletes or modifies subparagraph (a)(2) above, the offeror must furnish with its offer a signed statement setting forth in detail the circumstances of the disclosure.

K.8 TAX CERTIFICATION

Each offeror must submit with its offer, a sworn Tax Certification Affidavit, incorporated herein as Attachment J.2.3. [are there two?]

SECTION L: INSTRUCTIONS, CONDITIONS AND NOTICES TO OFFERORS

L.1 PROPOSAL IDENTIFICATION

Proposals shall be submitted in two parts titled: "Technical Proposal" and "Price Proposal" an original and nine (9) copies, each shall be submitted in a sealed envelope conspicuously marked: "Proposal in response to Solicitation No. POTO-2006-R-0077, Medicaid Management Information System. Proposals shall be typewritten in 12 point font size on 8.5" by 11" bond paper. Telephonic, telegraphic, and facsimile proposals will not be accepted.

L.2 HAND DELIVERY OR MAILING OF PROPOSALS

Nine (9) complete printed copies and one electronic copy in Microsoft Word Version 6.0 or higher must be delivered to or mailed to:

Office of Contracting and Procurement

Office of Procurement Administration

441 4th Street, N.W.

Bid Room, Suite 703 South

Washington, D.C. 20001

L.3 PROPOSAL SUBMISSION DATE AND TIME, AND LATE SUBMISSIONS, LATE MODIFICATIONS, AND LATE WITHDRAWALS

L.3.1 PROPOSAL SUBMISSION TIME

Proposals must be submitted no later than the date and time specified on page 1 of the solicitation. Proposals, modifications to proposals, or requests for withdrawals that are received in the designated District office after the exact local time specified, are "late" and shall be considered only if they are received before the award is made and one (1) or more of the following circumstances apply:

a. The proposal or modification was sent by registered or certified mail no later than the fifth (5th) calendar day before the date specified for receipt of offers;

b. The proposal or modification was sent by mail and it is determined by the Contracting Officer that the late receipt at the location specified in the solicitation was caused by mishandling by the District after receipt; or

c. The proposal is the only proposal received.

L.3.2 POSTMARKS

The only acceptable evidence to establish the date of a late proposal, late modification or late withdrawal sent either by registered or certified mail shall be a U.S. or Canadian Postal Service postmark on the wrapper or on the original receipt from the U.S. or Canadian Postal Service. If neither postmark shows a legible date, the proposal, modification or withdrawal shall be deemed to have been mailed late. When the postmark shows the date but not the hour, the time is presumed to be the last minute of the date shown. If no date is shown on the postmark, the proposal shall be considered late unless offeror can furnish evidence from the postal authorities of timely mailing.

L.3.3 LATE MODIFICATIONS

A late modification of a successful proposal, which makes its terms more favorable to the District, shall be considered at any time it is received and may be accepted.

L.3.4 LATE PROPOSALS

A late proposal, late modification or late withdrawal of offer that is not considered shall be held unopened, unless opened for identification, until after award and then retained with unsuccessful offers resulting from this solicitation.

L.4 EXPLANATIONS TO PROSPECTIVE OFFERORS

If a prospective offeror has any questions relative to this solicitation, the prospective offeror shall submit the question in writing to the contact person, identified on page one. The prospective offeror shall submit questions no later than **July 25, 2006 at 10:00 a.m.** The District will not consider any questions received after **July 25, 2006 at 10:00 a.m**. The District will furnish responses promptly to all other prospective offerors. An amendment to the solicitation will be issued if that information is necessary in submitting offers, or if the lack of it would be prejudicial to any other prospective offerors. Oral explanations or instructions given before the award of the contract will not be binding.

L.5 FAILURE TO SUBMIT OFFER

Recipients of this solicitation not responding with an offer should not return this solicitation. Instead, they should advise the Office of Contracting and Procurement, Office of Procurement Administration, 441 4th Street, N.W., Suite 700S, Washington, D.C. 20001, Telephone No. (202) 727-0252, by letter or postcard whether they want to receive future solicitations for similar requirements. It is also requested that such recipients advise the Office of Contracting and Procurement, of the reason for not submitting a proposal in response to this solicitation. If a recipient does not submit an offer and does not notify the Office of Contracting and Procurement that future solicitations are desired, the recipient's name may be removed from the applicable mailing list.

L.6 RESERVED

L.7 CONTRACT AWARD

L.7.1 CONTRACT AWARD - MOST ADVANTAGEOUS TO DISTRICT

The District intends, but is not obligated, to award a contract resulting from this solicitation to the responsible offeror whose offer conforming to the solicitation will be most advantageous to the District, cost or price, technical and other factors, specified elsewhere in this solicitation considered.

L.7.2 CONTRACT AWARD - INITIAL OFFERS

The District may award a contract on the basis of initial offers received, without discussion. Therefore, each initial offer should contain the offeror's best terms from a stand point of cost or price, technical and other factors.

L.8 PROPOSAL FORM , ORGANIZATION AND ORGANIZATION

All proposals must be submitted on 8.5" by 11" bond paper and typewritten, and also submitted on a CD. Telephonic and telegraphic proposals will not be accepted. The proposals shall be organized as follows:

L.8.1 SECTION I ATTACHMENTS

a. Attachments J.2.2, J.2.3, J.2.4 and J.2.5 of the solicitation and Section L.23, Proposal Guarantee, shall be completed and signed.

b. A copy of the letter from CMS indicating that the transfer MMIS has been unconditionally certified must also be enclosed in this Proposal section.

L.8.2 SECTION II TECHNICAL PROPOSAL

This section shall outline the Offeror's overall technical approach to perform the required services. This section shall include:

a) Detail on how the proposed system will meet the Data Processing Requirements as described in Section C.3 of the RFP. The proposal must address in detail each requirement. It is not acceptable to simply state that the proposed system will meet or exceed the requirements. A narrative must be written describing the data processing capabilities of the proposed system as compared and contrasted to the RFP requirements.

b) Detail on how the proposed system will meet the Operations Requirements as described in Section C.5 of the RFP. The proposal must address in detail each requirement. It is not acceptable to simply state that the proposed system will meet or exceed the requirements. A narrative must be written describing the data processing capabilities of the proposed system as compared and contrasted to the RFP requirements.

c) Detail on how the proposed system will meet the MMIS Functional Requirements as described in Section C.6 of the RFP. The proposal must address in detail each requirement. It is not acceptable to simply state that the proposed system will meet or exceed the requirements. A narrative must be written describing the data processing capabilities of the proposed system as compared and contrasted to the RFP requirements. Include a description of the transfer system modifications and/or enhancements necessary to meet the requirements of this RFP and the required level of effort.

d) A Proposal Requirements Cross-Reference Chart. This chart must depict a list of the above requirements of C.3, C.5 and C.6 and the associated page upon which the requirement response is included in the Offeror's proposal.

e) A plan which shall refer to the work to be performed as set forth in Sections C.7 through C.10, (Enhancement and Implementation Task, Operations Task, Modifications Task and Turnover Task). This plan shall describe how the work will be accomplished including the approach, methods, and specific work steps to complete all activities necessary to fulfill the tasks and provide the deliverables.

f) A detailed project workplan and schedule, that addresses all activities, tasks and subtasks required to complete the Enhancement and Implementation Task (C.7). The workplan must detail:

1. All activities;
2. Tasks;
3. Deliverables;
4. Significant milestones and events as envisioned by the Offeror;
5. Deliverable submission dates;
6. District deliverable review periods;
7. All tasks broken down into subtasks, not to exceed two (2) staff weeks of effort per category;
8. Estimated amounts of District and Offeror staff days shown separately and totaled for each task; and
9. GANTT charts showing the critical path and planned start and end dates of all activities, tasks and subtasks.

This section should be described in sufficient detail to permit the District to evaluate it in accordance with Section M, Evaluation of Proposals.

L.8.3 SECTION III ORGANIZATIONAL SUPPORT AND EXPERIENCE

This section shall contain all pertinent information relating to the Offeror's organization. This section shall include:

a) Resumes of key personnel to be assigned that satisfy the Organization and Staffing Requirements as described in Section C.4 of the RFP, the percentage of time that each will devote to the contract, and abstracts of experience that would substantiate their qualifications and capabilities to perform the services required by the scope of the work described in Sections C.7 – C.10 of the RFP.

b) Provide evidence of financial ability and capability to fulfill the RFP requirements. The Offeror must include in the proposal such financial documentation as they believe sufficient to establish their financial ability to successfully complete the project.

c) Include the information requested in Sections K.1, K.2, K.3, L.18 and L.19.

This section shall also include the following:

a) Location of headquarters;

b) A chart of the Offeror's internal organization which shows the number of full-time personnel and their level of responsibility within that organization;

c) The name of the person who manages the firm and makes policy for the Contractor and for any subcontractor; and

d) A list of all other proposed personnel with a minimum of three (3) years of experience and their specific functions on the contract, including the name of the staff member who is to be assigned primary responsibility.

e) A description of comparable organization experience within the last ten (10) years including, but not limited to: all related and relevant MMIS; Fiscal Intermediary; system design, enhancement and implementation; system operation; system transfer; and system maintenance and modification. Included in your response should be:

1. a narrative description of the work performed;
2. the term of the contract and staff months expended;
3. the contract cost;
4. the scheduled and actual completion dates for the design, enhancement, implementation, and post implementation tasks;
5. a description of any licensing Contracts;

6. disclosure of any liquidated or punitive damages imposed since January 1994, including the circumstances and amounts involved;
7. computer hardware, systems software, and programming languages used;
8. whether the work was performed as a prime or as a subcontractor;
9. the overall responsibilities of the Contractor or subcontractor staff assigned to the project, the functions they performed, and the percentage of their time allocated to the project; and
10. two (2) or more customer references (including name, address, and current telephone number of the responsible project administrator or manager) who are familiar with the Contractor' s product and project performance.

-

L.8.4 SECTION IV PRICE PROPOSAL

L.8.4.1 This section shall be submitted under a separate cover titled "Price Proposal". It shall include the total price for the entire project, and shall contain the following price schedules:

Pricing Schedule B.4 - Total Offer Price,

Pricing Schedule B.4.1 - Pricing Schedule for Enhancement and Implementation, and

Pricing Schedules B.4.2 - Pricing Schedules for Operations.

Pricing Schedule B.4.3. – Monthly Rates for Optional Resource Personnel

L.8.4.1.1 The offeror shall provide at a minimum the following in the Price Proposal:

a. A completed Section B – Schedule for a period of seven (7) years;
b. A completed Attachment J.2.5 – Cost/Price Disclosure Certification and Cost/Price Data Requirements to support the Prices proposed in Section B – Schedule for each of the CLIN; and
c. Cost/Price Narrative/Justifications and Supporting Documentation for costs and expenses as applicable.

L.8.4.2 Pricing Schedule B.4 summarizes the total prices offer for all Contractor activities during the contract period, including implementation and all seven (7) years of operations.

L.8.4.2.1 The Contractor must specify a firm fixed price for the Enhancement and Implementation activities and for each year of operations. The prices shown on Section B should equal those shown on Schedules B.4.

L.8.4.2.2 The total Price on Schedule B.4 will be the sum of the prices offer for all tasks, and all years of operation, excluding amounts offered for optional resource personnel. The price proposal shall contain the proposed price for each task.

L.8.4.3 Pricing Section B includes all design, enhancement, and implementation prices and shows the firm fixed price for the Enhancement and Implementation. The Offeror must show the total price for bringing the District of Columbia MMIS to operational readiness, for obtaining state approval, and for obtaining federal certification as addressed in subsection C.5.10. Offeror should note that this process could include Contractor funding the cost of state staff travel.

L.8.4.3.1 The breakout of prices by payment for task milestone completion, by fiscal year, allows the District to budget for Enhancement and Implementation payments. The offeror shall not include costs associated with the optional resource personnel.

L.8.4.4. The Contractor must specify a firm fixed unit price to perform all Contractor services for the claims volume indicated in schedule B.4.2 for each of the contract period of operations. Reimbursement to the offeror will not be made on a per claim basis, unless the actual number of claims processed falls outside the estimated threshold, as described in Subsection H.23.

L.8.4.4.1 All costs (machine time, personnel, and documentation support) for modification and maintenance support, as well as operations, are to be included in this fixed price offer for each year. offerors must not include costs for postage since these are reimbursement basis costs as specified in Subsection H.31. Any anticipated costs for the Turnover task should be included in Pricing Schedule B.4.2 for the last contract period of operations.

L.8.4.4.2 The District is requiring offers for optional resource personnel including two (2) health care data analysts and three (3) analyst/programmers. offerors are instructed to complete Section B for these optional resource personnel. Amounts offered for the optional resource personnel are not included in the total price on Pricing Section B. The District reserves the right to utilize all or any of the optional resource personnel

during any period of the contract. Any changes to resource levels will require a contract modification.

L.8.4.5 Pricing Schedule B.4.3. must reflect the monthly rates for optional resource personnel described in subsection C.4.6, Minimum Qualifications for Optional Resource Personnel. The monthly rate specified on Schedule B.4.3 should be for one full time person working 160 hours per month. Documentation supporting Contractor preferences, as described in Section M.3, should also be submitted if the Contractor qualifies.

L.9 COMPLETE PROPOSALS

Proposals shall represent the best efforts of the offeror and will be evaluated as such. Proposals must set forth full, accurate, and complete information as required by the solicitation.

L.10 KEY PERSONNEL

L.10.1 PROPOSAL INFORMATION

The Contractor shall provide in its proposal as set forth in Section L.8.3, Section III, the names and reporting relationships of the key personnel whom the offeror will use to perform the work under the proposed contract. Their resumes shall be included in Section III. The hours each will devote to the contract shall be provided in total and broken down by task in this section.

L.10.2 DIVERSION, REASSIGNMENT AND REPLACEMENT OF KEY PERSONNEL

The key personnel specified in the contract are considered to be essential to the work being performed hereunder. Prior to diverting any of the specified key personnel for any reason, the offeror shall notify the Contracting Officer at least thirty (30) calendar days in advance and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the contract. The Contractor shall not reassign these key personnel or appoint replacements, without written permission from the Contracting Officer.

L.11 UNNECESSARILY ELABORATE PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective response to this solicitation are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor

desired.

L.12 RETENTION OF PROPOSALS

All proposal documents shall be the property of the District and retained by the District, and, therefore, will not be returned to the offerors.

L.13 EXAMINATION OF SOLICITATION

Contractors are expected to examine the Statement of Work and all instructions and attachments in this solicitation. Failure to do so will be at the Contractor's risk.

L.14 BEST AND FINAL OFFERS

If, subsequent to receiving original proposals, negotiations are conducted, all offerors within the competitive range will be so notified regarding such negotiations and will be provided an opportunity to submit written best and final offers at the designated date and time. Submission of best and final offers are subject to the Late Submissions, Late Modifications and Late Withdrawals of Proposals provision of this solicitation. After receipt of best and final offers, no discussions will be reopened unless the Contracting Officer determines that it is clearly in the government's best interest to do so. If discussions are reopened, the Contracting Officer shall issue an additional request for best and final offers to all Contractors still within the competitive range.

L.15 ACKNOWLEDGEMENT OF AMENDMENTS

Contractors shall acknowledge receipt of any amendment to this solicitation (a) by signing and returning the amendment; (b) by identifying the amendment number and date in the space provided for this purpose; or (c) by letter or telegram including mailgrams. The District must receive the acknowledgement by the date and time specified for receipt of offers. Contractor's failure to acknowledge an amendment may result in rejection of the offer.

L.16 ACCEPTANCE PERIOD

The Contractor agrees, if its offer is accepted within one hundred and twenty (120) days from the date specified in the solicitation for the submission of proposals or if its last round best and final offer is accepted within ninety (90) days from the date specified for submission thereof, to furnish services at the price stated in the Price Proposal, delivered or performed at the designated place within the time specified in this solicitation.

L.17 CERTIFICATES OF INSURANCE

The Contractor shall submit certificates of insurance giving evidence of the required coverages as specified in Section I.8 prior to commencing work. Evidence of insurance shall be submitted within fourteen (14) days of contract award to:

William Sharp
Contracting Officer
441 4th Street, NW, Suite 700 South
Washington, DC 20001
202-727-0252
William.sharp@dc.gov

L.18 LEGAL STATUS OF OFFEROR

Each proposal must provide the following information:

L.18.1 Name, address, telephone number and federal tax identification number of offeror;

L.17.2 A copy of each District of Columbia license, registration or certification that the offeror is required by law to obtain. This mandate also requires the offeror to provide a copy of the executed "Clean Hands Certification" that is referenced in D.C. Official Code §47-2862 (2001), if the offeror is required by law to make such certification. If the offeror is a corporation or partnership and does not provide a copy of its license, registration or certification to transact business in the District of Columbia, the offer shall certify its intent to obtain the necessary license, registration or certification prior to contract award or its exemption from such requirements; and

L.17.3 If the offeror is a partnership or joint venture, the names and addresses of the general partners or individual members of the joint venture, and copies of any joint venture or teaming agreements.

L.19 ORGANIZATION OF OFFEROR

Each proposal must further contain a chart showing the internal organization of the offeror and the numbers of full-time personnel in each organizational unit.

L.20 COST OR PRICING INFORMATION

Offerors shall submit cost and pricing data for each item identified on Proposal Pricing Schedules and a certification that, to the best of the offeror's knowledge and belief, the cost or pricing data submitted was accurate, complete, and current as of the date submitted with the proposal. See also the Standard Contract Provisions for use with District of Columbia Government Supply and Services Contracts dated November 2004.

L.21 CERTIFICATIONS AND REPRESENTATIONS

Offerors shall complete and return with their proposal the Representations and Certifications, the Equal Employment Opportunity Forms, Attachment J.2, and Tax Certification, Attachment J.5.

L.22 SIGNING OF OFFERS

The offeror shall sign the offer or proposal and print or type its name on the Offer/Award form, Section A of this solicitation. Erasures or other changes must be initialed by the person signing the offer. Offers signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the Contracting Officer.

L.23 PROPOSAL GUARANTEE

Each proposal submitted by an offeror must be accompanied by a written guarantee that the offeror will keep its initial offer open for at least the acceptance period specified in Section L.16; that if negotiations are held, it will keep its best and final offer open for a period of at least ninety (90) days from the date set for submission of the final round of best and final offers; and upon acceptance by the District of its initial proposal or best and final offer, that it will execute the contract and meet other requirements within the times specified in the solicitation or District's request.

L.24 PREPROPOSAL CONFERENCE

A pre-proposal conference will be held at **9:00 a.m,** on **July 14, 2006** at 441 4th Street, N,W., Suite 700, Washington, DC 20001. Prospective offerors will be given an opportunity to ask questions regarding this solicitation at the conference.

The purpose of the conference is to provide a structured and formal opportunity for the District to accept questions from offerors on the RFP document as well as to clarify the contents of the RFP. Any major revisions to the RFP as a result of the conference, or answers to deferred questions will be made in the form of written addenda to the original RFP. These questions and the District's answers will be posted on the OCP website, http://ocp.dc.gov. The District may also distribute additional background information or material at the conference.

Attending offerors must complete the Pre-Proposal Conference Attendance Registration Cards distributed at the beginning of the conference so that offeror attendance can be properly recorded. The completed registration cards must be submitted to a District Staff representative at the conclusion of the conference.

Impromptu questions will be permitted and spontaneous answers will be provided at the District's discretion. Verbal answers at the pre-proposal conference are only intended for general direction and to not represent the Department's final position. All oral questions must be submitted in writing following the close of the pre-proposal conference but no later than five (5) working days after the pre-proposal conference in order to generate an official

answer. Official answers will be provided in writing to all prospectors offerors who is listed of the official bidder's list has having received a copy of the solicitation. Answers will also be post on both websites.

L.25 QUESTIONS AND INQUIRIES

It is the policy of the District of Columbia Office of Contracting and Procurement to accept questions and inquiries from all potential offerors who have received this RFP.

Offerors are encouraged to submit WRITTEN questions in advance of the Pre-Proposal Conference so that answers may be prepared by the time of the conference.

L.25 RESTRICTION ON DISCLOSURE AND USE OF DATA

L.25.1 Offerors who include in their proposal data that they do not want disclosed to the public or used by the District except for use in the procurement process shall mark the title page with the following legend:

"This proposal includes data that shall not be disclosed outside the District and shall not be duplicated, used or disclosed in whole or in part for any purpose except for use in the procurement process.

If, however, a contract is awarded to this offeror as a result of or in connection with the submission of this data, the District will have the right to duplicate, use, or disclose the data to the extent consistent with the District's needs in the procurement process. This restriction does not limit the District's rights to use, without restriction, information contained in this proposal if it is obtained from another source. The data subject to this restriction are contained in sheets (insert page numbers or other identification of sheets)."

L.25.2 Mark each sheet of data it wishes to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this proposal."

L.26 PROPOSALS WITH OPTION YEARS

The offeror shall include option year prices in its price/cost proposal. An offer may be determined to be unacceptable if it fails to include option year pricing.

L.27 PROPOSAL PROTESTS

Any actual or prospective offeror or contractor who is aggrieved in connection with the solicitation or award of a contract, must file with the D.C. Contract Appeals Board (Board) a protest no later than 10 business days after the basis of protest is known or should have been

known, whichever is earlier. A protest based on alleged improprieties in a solicitation which are apparent at the time set for receipt of initial proposals shall be filed with the Board prior to the time set for receipt of initial proposals. In procurements in which proposals are requested, alleged improprieties which do not exist in the initial solicitation, but which are subsequently incorporated into the solicitation, must be protested no later than the next closing time for receipt of proposals following the incorporation. The protest shall be filed in writing, with the Contract Appeals Board, 717 14th Street, N.W., Suite 430, Washington, D.C. 20004. The aggrieved person shall also mail a copy of the protest to the Contracting Officer for the solicitation.

L.28 SIGNING OF OFFERS

The offeror shall sign the offer and print or type its name on the Solicitation, Offer and Award form of this solicitation. Offers signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the Contracting Officer.

L.29 UNNECESSARILY ELABORATE PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective response to this solicitation are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate artwork, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor desired.

L.30 PROPOSAL COSTS

The District is not liable for any costs incurred by the offerors in submitting proposals in response to this solicitation.

L.31 ELECTRONIC COPY OF PROPOSALS FOR FREEDOM OF INFORMATION ACT REQUESTS

In addition to other proposal submission requirements, the offeror must submit an electronic copy of its proposal, redacted in accordance with any applicable exemptions from disclosure in D.C. Official Code § 2-534, in order for the District to comply with Section 2-536(b) that requires the District to make available electronically copies of records that must be made public. The District' s policy is to release documents relating to District proposals, subject to applicable FOIA exemption under Section 2-534(a)(1).

L.32 FAMILIARIZATION WITH CONDITIONS

Offerors shall thoroughly familiarize themselves with the terms and conditions of this solicitation, acquainting themselves with all available information regarding difficulties which may be encountered, and the conditions under which the work is to be accomplished. Contractors will not be relieved from assuming all responsibility for properly estimating the

difficulties and the cost of performing the services required herein due to their failure to investigate the conditions or to become acquainted with all information, schedules and liability concerning the services to be performed.

L.33 STANDARDS OF RESPONSIBILITY

The prospective Contractor must demonstrate to the satisfaction of the District the capability in all respects to perform fully the contract requirements; therefore, the prospective Contractor must submit the documentation listed below, within five (5) days of the request by the District.

L.33.1 Evidence of adequate financial resources, credit or the ability to obtain such resources as required during the performance of the contract.

L.33.2 Evidence of the ability to comply with the required or proposed delivery or performance schedule, taking into consideration all existing commercial and governmental business commitments.

L.33.3 Evidence of the necessary organization, experience, accounting and operational control, technical skills or the ability to obtain them.

L.33.4 Evidence of compliance with the applicable District licensing and tax laws and regulations.

L.33.5 Evidence of a satisfactory performance record, record of integrity and business ethics.

L.33.6 Evidence of the necessary production, construction and technical equipment and facilities or the ability to obtain them.

L.33.7 Evidence of other qualifications and eligibility criteria necessary to receive an award under applicable laws and regulations

L.33.8 If the prospective Contractor fails to supply the information requested, the Contracting Officer shall make the determination of responsibility or nonresponsibility based upon available information. If the available information is insufficient to make a determination of responsibility, the Contracting Officer shall determine the prospective Contractor to be nonresponsible.

L.34 ORAL PRESENTATIONS AND DEMONSTRATION OF THE BASE SYSTEM

Upon completion of the technical evaluations of proposals received in response to this solicitation those offerors determined to be in the competitive range shall provide Oral Presentations and a demonstration of the Base System to the technical evaluation panel and District officials. Points will not be awarded for oral presentations and the demonstration of the BASE system.

L34.1 Oral Presentations and the system demonstration will be scheduled by the Contracting Officer (CO). The CO will advise offerors of the date and time for the presentation and system demonstration of their Technical Proposal. The District reserves the right to reschedule presentations at the sole discretion of the CO.

L.34.2 Offerors shall bring no more than six representatives to the Oral Presentation and the system demonstration, one of which shall be the Account Manager.

L. 34.3 The system demonstration shall be no longer than 2 hours. The Oral Presentation shall be no longer than 75 minutes in total duration utilizing the following format, outline, time limits, and description of information to be discussed or provided during the presentation:

L.34.3.1 Introduction, five (5) minutes limit, including an overview of the organization, its mission, and philosophy to successfully completing the District's requirements.

L. 34.3.2 Technical Approach, forty (40) minutes limit, shall include the offeror's understanding of the District's requirements and the offeror's approach to comprehensively and successfully performing the District's requirements.

L.34.3.3 Technical Capability, fifteen (15) minutes limit, shall include the offeror's personnel and skill mix to perform services under this contract, the offeror's corporate structure and relationship of that structure to the successful completion of the contract requirements

L.34.3.4 Previous Experience/Past Performance, fifteen (15) minutes limit, and shall include a discussion of the offeror's previous experience and past performance providing services similar in scope and complexity as those described in Section C.

L.34.3.5 Explanation to questions, maximum of thirty (30) minutes, after completion of the oral presentation, the government may request clarification of any of the points addressed which are unclear and may ask for elaboration by the offeror on any point which was not adequately supported in the presentation. The time required for explanation will not be counted against the offeror's 75 minute limit.

L.34.4 Oral Presentations shall be delivered and formatted utilizing Microsoft PowerPoint Slides. All offerors shall document the main points of the oral presentation on slides formatted in Microsoft PowerPoint and provide an original and ten (10) printed copies of the slides to the CO prior to the beginning of the Oral Presentation. Copies of the presentation slides shall be prepared landscape style on 8 1/2 by 11 inch paper and can be prepared in any type face easily readable in an overhead projection presentation format. The offeror is responsible for providing a person (one of the three representatives) responsible for the movement through the slide presentation if it will not be done by the briefer.

SECTION M - EVALUATION FACTORS

M.1 EVALUATION FOR AWARD

The contract will be awarded to the responsible offeror whose offer is most advantageous to the District, based upon the evaluation criteria specified below. Thus, while the points in the evaluation criteria indicate their relative importance, the total scores will not necessarily be determinative of the award. Rather, the total scores will guide the District in making an intelligent award decision based upon the evaluation criteria.

M.2 TECHNICAL RATING

The Technical Rating Scale is as follows:

Numeric Rating	Adjective	Description
0	Unacceptable	Fails to meet minimum requirements; e.g., no demonstrated capacity, major deficiencies which are not correctable; offeror did not address the factor.
1	Poor	Marginally meets minimum requirements; major deficiencies which may be correctable.
2	Minimally Acceptable	Marginally meets minimum requirements; minor deficiencies which may be correctable.
3	Acceptable	Meets requirements; no deficiencies.
4	Good	Meets requirements and exceeds some requirements; no deficiencies.
5	Excellent	Exceeds most, if not all requirements; no deficiencies.

For example, if a sub factor has a point evaluation of 0 to 6 points, and (using the Technical Rating Scale) the District evaluates as "good" the part of the proposal applicable to the sub factor, the score for the sub factor is 4.8 (4/5 of 6). The sub factor scores will be added together to determine the score for the factor level.

M.3 EVALUATION CRITERIA

Proposals will be evaluated based on the following technical evaluation factors listed in descending order of importance**.**

M.3.1 TECHNICAL CRITERIA (85 POINTS)

M.3.1.1 Plan for Accomplishing Tasks - 25 Points

Points in this category will be awarded based upon evaluation of the offeror's technical plan for meeting the requirements and accomplishing the tasks in Sections C.3 through C.10 of the RFP. Evaluation will be based upon:

a) Demonstrated understanding of the District objectives and requirements;

b) Demonstrated capabilities satisfying the Data Processing, Operations, and MMIS Functional Requirements as described in Sections C.3, C.5, and C.6 of the RFP;

c) Approach to Enhancement and Implementation tasks as described in Section C.7 of the RFP;

d) Approach to Operations, Modifications, and Turnover tasks as described in Section C.8 through C.10 of the RFP;

e) Approach to project management and control;

f) Comprehensiveness of the offeror' s approach and plan, including the specific work steps, as measured by the quality of the plan's coverage of all tasks and deliverables necessary to complete the requirements set forth in Sections C.7 through C.10 of the RFP; and

g) Feasibility of the offeror' s detailed project workplan and schedule that addresses all activities, tasks, and subtasks to complete the Enhancement and Implementation task as described in Section C.7 of the RFP and as measured by the proposed level of effort, planned task duration, and delivery dates.

M.3.1.2 Expertise and Capability of Staff - 20 Points

Points in this category will be awarded based on the offeror' s staff experience meeting the requirements of Section C.4 of the RFP and conveyed in its proposal and using information obtained in the testimony of references. A substantial portion of the points are available for evaluation of the proposed project manager and key staff. Evaluation will be based upon staff experience with:

a) MMIS Enhancement and Implementation;

b) MMIS operations;

c) Comparable projects performed under contract for government agencies;

d) Medicaid Program automation and MMIS enhancement and maintenance;

e) Other large scale medical and/or claims processing operations;

f) Implementation of systems with similar architecture, volume, and performance characteristics; and

g) Project management and control of a project of similar scope and complexity.

M.3.1.3 Offeror's Experience - 20 Points

Points in this category will be awarded based upon evaluation of the offeror's background and experience relevant to the requirements as described in Section C of the RFP Evaluation will be based upon firm experience within the last ten (10) years with:

a) Financial ability and capability to fulfill the requirements of the RFP based on financial resources;

b) MMIS Enhancement and Implementation;

c) MMIS operations;

d) Comparable projects performed under contract for government agencies;

e) Medicaid program automation and MMIS enhancement and maintenance;

f) Other large scale medical and/or claims processing operations; and

g) Implementation of systems with similar architecture, volume, and performance characteristics

M.3.1.4 PAST PERFORMANCE (20 POINTS)

M.3.1.4.1 Past Performance of Staff (10 points)

M.3.1.4.1.1 This factor considers the past performance of staff in performing services similar to the required services as described in Section C of this solicitation. This factor includes an examination of the quality of services provided, timeliness in service delivery, business practices, and overall satisfaction of staff performance

M.3.1.4.1.2 The Offeror shall provide references for the proposed project manager and key staff for all positions in which they have performed similar work in the past five (5) years. Work is similar, if the function, responsibilities, and duties of the

offeror are essentially the same as the required services described in Section C of the RFP.

M.3.1.4.2 Past Performance of Offeror (10 points)

M.3.1.4.2.1 This factor considers the past performance of the Offeror in performing services similar to the required services as described in Section C of this solicitation. This factor includes an examination of the quality of services provided, timeliness in service delivery, business practices, and overall satisfaction of the Offeror's performance.

M.3.1.4.2 .2 The Offeror shall provide references for all contracts in which it has performed similar work in the past ten (10) years. Work is similar, if the function, responsibilities, and duties of the offeror are essentially the same as the required services described in Section C of the RFP.

M.3.2 PRICE CRITERIA (15 POINTS)

The price evaluation will be objective. The offeror with the lowest firm-fixed-price will receive the maximum points. All other proposals will receive a proportionately lower total score. Documentation supporting Contractor preferences, as described in Section M.3, should be submitted if the Contractor qualifies. The following formula will be used to determine each Offeror's evaluated price score:

$$\frac{\text{Lowest fixed price proposal}}{\text{Fixed price of proposal being evaluated}} \times \text{Weight} = \text{Evaluated price score}$$

M.3.3 DISTRICT/FEDERAL APPROVALS AND AWARD OF CONTRACT

Contract approval is contingent upon both the District and Federal approvals. Every effort will be made by the District, both before and after selection, to facilitate rapid approval in order that the project may begin according to its scheduled start date. Once all District and Federal approvals have been granted, the selected Contractor will be notified that work can begin.

M.4 OPEN MARKET CLAUSES WITH LSDBE SUBCONTRACTING SET-ASIDE (SUPPLIES AND SERVICES)

M.4.1 **Preferences for Local Businesses, Disadvantaged Businesses, Resident-owned Businesses, Small Businesses, Longtime Resident Businesses, or Local Businesses with Principal Offices Located in an Enterprise Zone**

Under the provisions of the "Small, Local, and Disadvantaged Business Enterprise Development and Assistance Act of 2005" (the Act), Title II, Subtitle N, of the "Fiscal Year 2006 Budget Support Act of 2005", D.C. Law 16-33, effective October 20, 2005, the District shall apply preferences in evaluating bids or proposals from businesses that are small, local, disadvantaged, resident-owned, longtime resident, or local with a principal office located in an enterprise zone of the District of Columbia.

M.4..1.1 **Required Subcontracting Set-Aside**

25 % of the total dollar value of this contract has been set-aside for performance through subcontracting with businesses certified by the Small and Local Business Opportunity Commission (SLBOC) or the Department of Small and Local Business Development (DSLBD), as applicable, as local business enterprises, disadvantaged business enterprises, resident-owned businesses, local business enterprises with their principal offices located in an enterprise zone, small business enterprises, or longtime resident businesses. Any prime Contractor responding to this solicitation shall submit within 5 days of the contracting officer's request, a notarized statement detailing its subcontracting plan. Once the plan is approved by the contracting officer, changes will only occur with the prior written approval of the contracting officer and the Director of DSLBD.

M.4.2 **General Preferences**

For evaluation purposes, the allowable preferences under the Act for this procurement are as follows:

M.4.2.1 Three percent reduction in the bid price or the addition of three points on a 100-point scale for a small business enterprise (SBE) certified by the Small and Local Business Opportunity Commission (SLBOC) or the Department of Small and Local Business Development (DSLBD), as applicable;

M.4.2.2 Three percent reduction in the bid price or the addition of three points on a 100-point scale for a resident-owned business enterprise (ROB) certified by the SLBOC or the DSLBD, as applicable;

M.4.2.3 Ten percent reduction in the bid price or the addition of ten points on a 100-point scale for a longtime resident business (LRB) certified by the SLBOC or the DSLBD, as applicable;

M.4.2.4 Two percent reduction in the bid price or the addition of two points on a 100-point scale for a local business enterprise (LBE) certified by the SLBOC or the DSLBD, as applicable;

M.4.2.5 Two percent reduction in the bid price or the addition of two points on a 100-point scale for a local business enterprise with its principal office located in an enterprise zone (DZE) and certified by the SLBOC or the DSLBD, as applicable; and

M.4.2.6 Two percent reduction in the bid price or the addition of two points on a 100-point scale for a disadvantaged business enterprise (DBE) certified by the SLBOC or the DSLBD, as applicable.

M.4.3 **Application of Preferences**

The preferences shall be applicable to prime Contractors as follows:

M.4.3.1 Any prime contractor that is an SBE certified by the SLBOC or the DSLBD, as applicable, will receive a three percent (3%) reduction in the bid price for a bid submitted by the SBE in response to an Invitation for Bids (IFB) or the addition of three points on a 100-point scale added to the overall score for proposals submitted by the SBE in response to a Request for Proposals (RFP).

M.4.3.2 Any prime contractor that is an ROB certified by the SLBOC or the DSLBD, as applicable, will receive a three percent (3%) reduction in the bid price for a bid submitted by the ROB in response to an IFB or the addition of three points on a 100-point scale added to the overall score for proposals submitted by the ROB in response to an RFP.

M.4.3.3 Any prime contractor that is an LRB certified by the SLBOC or the DSLBD, as applicable, will receive a ten percent (10%) reduction in the bid price for a bid submitted by the LRB in response to an IFB or the addition of ten points on a 100-point scale added to the overall score for proposals submitted by the LRB in response to an RFP.

M.4.3.4 Any prime contractor that is an LBE certified by the SLBOC or the DSLBD, as applicable, will receive a two percent (2%) reduction in the bid price for a bid submitted by the LBE in response to an IFB or the addition of two points on a 100-point scale added to the overall score for proposals submitted by the LBE in response to an RFP.

M.4.3.5 Any prime contractor that is a DZE certified by the SLBOC or the DSLBD, as applicable, will receive a two percent (2%) reduction in the bid price for a bid submitted by the DZE in response to an IFB or the addition of two points on a 100-point scale added to the overall score for proposals submitted by the DZE in response to an RFP.

M.4.3.6 Any prime contractor that is a DBE certified by the SLBOC or the DSLBD, as applicable, will receive a two percent (2%) reduction in the bid price for a bid submitted by the DBE in response to an IFB or the addition of two points on a 100-point scale added to the overall score for proposals submitted by the DBE in response to an RFP.

M.4.4 **Maximum Preference Awarded**

Notwithstanding the availability of the preceding preferences, the maximum total preference to which a certified business enterprise is entitled under the Act for this procurement is twelve percent (12%) for bids submitted in response to an IFB or the equivalent of twelve (12) points on a 100-point scale for proposals submitted in response to an RFP. There will be no preference awarded for subcontracting by the prime contractor with certified business enterprises.

M.4.5 Preferences for Certified Joint Ventures

When the SLBOC or the DSLBD, as applicable, certifies a joint venture, the certified joint venture will receive preferences as a prime contractor for categories in which the joint venture and the certified joint venture partner are certified, subject to the maximum preference limitation set forth in the preceding paragraph.

M.4.6 **Vendor Submission for Preferences**

M.4.6.1 Any vendor seeking to receive preferences on this solicitation must submit at the time of, and as part of its bid or proposal, the following documentation, as applicable to the preference being sought:

M.4.6.1.1 Evidence of the vendor's or joint venture's certification by the SLBOC as an SBE, LBE, DBE, DZE, LRB, or RBO**,** to include a copy of all relevant letters of certification from the SLBOC; or

M.4.6.1.2 Evidence of the vendor's or joint venture's provisional certification by the DSLBD as an SBE, LBE, DBE, DZE, LRB, or RBO, to include a copy of the provisional certification from the DSLBD.

M.4.6.*2* Any vendor seeking certification or provisional certification in order to receive preferences under this solicitation should contact the:

Department of Small and Local Business Development
ATTN: LSDBE Certification Program
441 Fourth Street, N.W., Suite 970N
Washington, DC 20001

M.4.6.3 All vendors are encouraged to contact the DSLBD at (202) 727-3900 if additional information is required on certification procedures and requirements.

M.4.7 **Subcontracting Plan**

Any prime contractor responding to a solicitation in which there is an LBE, DBE, SBE, DZE, LRB, or ROB subcontracting set-aside, shall submit, within 5 days of the contracting officer's request, a notarized statement detailing its subcontracting plan. Each subcontracting plan shall include the following:

M.4.7.1 A description of the goods and services to be provided by the LBEs, DBEs, SBEs, DZEs, LRBs, or ROBs;

M.4.7.2 A statement of the dollar value, by type of business enterprise, of the bid or proposal that pertains to the subcontracts to be performed by the LBEs, DBEs, SBEs, DZEs, LRBs, or ROBs;

M.4.7.3 The names and addresses of all proposed subcontractors who are LBEs, DBEs, SBEs, DZEs, LRBs, or ROBs;

M.4.7.4 The name of the individual employed by the prime contractor who will administer the subcontracting plan, and a description of the duties of the individual;

M.4.7.5 A description of the efforts the prime contractor will make to ensure that LBEs, DBEs, ROBs, SBEs, LRBs, or DZEs will have an equitable opportunity to compete for subcontracts;

M.4.7.6 In all subcontracts that offer further subcontracting opportunities, assurances that the prime contractor will include a statement, approved by the contracting officer, that the subcontractor will adopt a subcontracting plan similar to the subcontracting plan required by the contract;

M.4.7.7 Assurances that the prime contractor will cooperate in any studies or surveys that may be required by the contracting officer, and submit periodic reports, as requested by the contracting officer, to allow the District to determine the extent of compliance by the prime contractor with the subcontracting plan;

M.4.7.8 List the type of records the prime contractor will maintain to demonstrate procedures adopted to comply with the requirements set forth in the subcontracting plan, and include assurances that the prime contractor will make such records available for review upon the District's request; and

M.4.7.9 A description of the prime contractor's recent effort to locate LBEs**,** DBEs, SBEs, DZEs, LRBs, and ROBs**,** and to award subcontracts to them.

M.4.8 **Enforcement and Penalties for Willful Breach of Subcontracting Plan**

The willful breach by a contractor of a subcontracting plan for utilization of local, small, or disadvantaged businesses in the performance of a contract, the failure to submit any required

subcontracting plan monitoring or compliance report, or the deliberate submission of falsified data may be enforced by the DSLBD through the imposition of penalties, including monetary fines of $15,000 or 5% of the total amount of the work that the contractor was to subcontract to local, small, or disadvantaged businesses, whichever is greater, for each such breach, failure, or falsified submission.

M.5 EVALUATION OF PROMPT PAYMENT DISCOUNT

M.5.1 Prompt payment discounts shall not be considered in the evaluation of offers. However, any discount offered will form a part of the award and will be taken by the District if payment is made within the discount period specified by the offeror.

M.5.2 In connection with any discount offered, time will be computed from the date of delivery of the supplies to carrier when delivery and acceptance are at point of origin, or from date of delivery at destination when delivery, installation and acceptance are at that, or from the date correct invoice or voucher is received in the office specified by the District, if the latter date is later than date of delivery. Payment is deemed to be made for the purpose of earning the discount on the date of mailing of the District check.